

FILIAL THERAPY WITH TEACHERS OF DEAF AND  
HARD OF HEARING PRESCHOOL CHILDREN

David Michael Smith, B.A., M.Div.

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APPROVED:

Garry Landreth, Major Professor  
Kenneth Sewell, Minor Professor  
Sue Bratton, Committee Member  
Janice Holden, Program Coordinator  
Michael Altedruse, Chair of the Department of  
Counseling, Development, and Higher  
Education  
C. Neal Tate, Dean of the Robert B. Toulouse  
School of Graduate Studies

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The purpose of this study was to determine the effectiveness of Filial Therapy training in increasing teachers of deaf and hard of hearing preschool students': 1) empathic responsiveness with their students; 2) communication of acceptance to their students; 3) allowance of self-direction by their students. A second purpose was to determine the effectiveness of Filial Therapy training in reducing experimental group students': 1) overall behavior problems; 2) internalizing behaviors; and 3) externalizing behavior problems.

Filial Therapy is a didactic/dynamic modality used by play therapists to train parents and teachers to be therapeutic agents with their children and students. Teachers are taught primary child-centered play therapy skills for use with their own students in weekly play sessions with their students. Teachers learn to create a special environment that enhances and strengthens the teacher-student emotional bond by means of which both teacher and child are assisted in personal growth and change.

The experimental group (N=24) consisted of 12 teachers, who participated in 11 weekly Filial Therapy training sessions (22 total instructional hours) during the fall semester at the preschool of a center for communications disorders, and 12 students chosen by the teachers as their student of focus.

Teachers and students met once a week during the training for 30 minute teacher student play sessions in a room specified for this purpose. The non-treatment comparison group received no training during the 11 weeks. Teacher participants completed two written instruments: the Child Behavior Checklist/Caregiver-Teacher Report Form and the Meadow-Kendall Social-

Emotional Assessment Inventory for Deaf and Hearing Impaired Students. Teachers who received Filial Therapy training were videotaped during student teacher play sessions. The videotaped sessions were used for pretest and posttest evaluation for the Measurement of Empathy in Adult-Child Interaction.

Analysis of covariance revealed the children in the experimental group significantly decreased overall behavior problems. Teachers in the experimental group increased communication of empathy with their students of focus, significantly increased their attitude of acceptance with their students, and significantly increased in their ability to allow the students appropriate self-direction. This study supports Filial Therapy as an effective method of training teachers of deaf and hard of hearing preschool children to be therapeutic agents of change with their students.

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## CHAPTER I

### INTRODUCTION

The problem of deafness and limited hearing in human beings has been a part of the human story since before recorded history. In the United States, since the beginning of the public education system, educators, teachers, physicians, counselors, social workers, and other helping professionals have sought to discover and implement effective methods of educating, socializing, and meeting the emotional needs of children who are deaf and hard of hearing (Harris, VanZandt, & Rees, 1997). Children who are born deaf, or who later become deaf or experience a loss of hearing within the first few years of their lives, often have significant difficulty acquiring language and the ability to communicate with others (Allen, 1986; Bebkco, 1998; Bond, 1987; Cates, 1991; DeSelle, 1994; Marshark & Clark, 1993). Difficulty in acquiring the ability to communicate and express self can greatly impact a child's cognitive, social, and emotional development (Deselle, 1994; Deselle & Pearlmutter, 1997; Furstenberg & Doyal, 1994; Hagborg, 1989; Vernon & Koh, 1970; Warren & Hasenstab, 1986). Despite the committed efforts of educators, teachers, school counselors, and other helping professionals, many deaf and hard of hearing children struggle to form satisfactory social relationships with individuals in their world, and to develop the emotional health and maturity commensurate with their hearing counterparts (Murdock & Lybarger, 1997-1998; Obrzut, Maddock, & Lee, 1999).

Whether deaf and hard of hearing students are educated in special education classes within the mainstream public education system, in public or private schools designed for deaf and hard of hearing students only, or in residential schools for deaf and hard of hearing students, research studies confirm that these students experience higher incidences of behavioral and emotional difficulties within the school environment (Mantanini-Manfredi, 1993; Vernon &

Andrews, 1990). Perhaps because deaf and hard of hearing children initially experience greater difficulty expressing their needs, wants, thoughts, and feelings than do their hearing peers, they tend to exhibit lower self-esteem and less ability to show empathy for others (Lederberg, 1991; Marschark & Clark, 1993; Vernon & Andrews, 1990). In addition, they experience higher incidences of depression, anger, aggression, frustration, impulsivity, estrangement, and isolation (Leigh, Robins, Welkowitz, & Bond, 1989; Luterman, 1999; Watt & Davis, 1991).

Most often, pre and elementary special schools for deaf and hard of hearing children respond to students' increased emotional needs by using specially trained school counselors for this purpose (Harris, VanZandt, & Rees, 1997; White, Flynt, & Jones, 1999). Classroom teachers and paraprofessionals often refer students with special behavioral and emotional needs to the school counselor or psychologist for consultation. Usually, the classroom teacher (sometimes with the assistance of a classroom paraprofessional) consults with the school counselor to develop a plan of intervention specifically targeted to assist the individual student with his or her particular emotional difficulty (Draper, White, O'Shaughnessy, Flynt, & Jones, 2001).

Following the consultation, the counselor works therapeutically one to one with the student as the counselor's schedule permits. The counselor conducts the therapeutic session either in the classroom or a more private setting available within the school (White, Flynt, & Draper, 1997). Sometimes counselors work with several children in social skills or treatment groups as the situation allows. At times the classroom teacher and counselor may work together to implement the agreed to plan both in the classroom and in the therapy room (White et al., 1997). However, the school counselor is often unable to have enough therapy sessions to affect lasting change in each student referred for treatment (Jeannie Allen, personal communication, March 30, 2001). Also, when a teacher makes referrals for children's emotional and social

difficulties to the school counselor, and the counselor works with the child away from the classroom, the teacher is deprived of the ability to watch and learn to implement new ways of relating to and being with children that the teacher might subsequently use to assist pupils in the classroom (White et al., 1997). Thus, any chance that the classroom teacher will be able include in her teaching arsenal helping skills potentially learned from the counselor will be diminished by the teacher's not being a part of the counselor's helping the referred student. It appears that a more comprehensive approach is needed to help deaf and hard of hearing preschool teachers assist deaf and hard of hearing students not only in acquiring language and the ability to express themselves, but also to assist in the healthy development of their social and emotional needs as well.

Research has documented the use of play therapy as a viable therapeutic means of assisting children with self-expression, when facilitated by the emotionally safe presence of the play therapist (Axline, 1947; Bratton, & Ray, 2000; Gil, 1994; Ginott, 1961; Landreth, 1991; Moustakas, 1959). Though there have been very few research studies using play therapy with deaf and hard of hearing children, Oualline, (1975) found that short-term, nondirective individual play therapy with deaf and hard of hearing children facilitated an increase in mature behavior patterns. However, hypotheses related to expected improvements in personality adjustment and manifest behavior were not supported by the data analysis.

Also, play therapy and filial therapy have been shown to be clinically efficacious in training school counselors to work therapeutically with students in pre, elementary, and middle school settings (B. Guernsey, 1964; L. Guernsey, 2000; Landreth, 1991). Building on the work of Axline (1947) and Moustakas (1959), Landreth (1991) elaborated the concept that for all children, regardless of their developmental or special needs, play is their most natural means of

communication. Play is an innate and universal means for children to express themselves. Through play, young children learn about reality and their world, experiment with pretend roles, and come to know themselves, their specific abilities and strengths. “In play, the child is dealing in a sensory-motor way with concrete objects which are symbols for something else the child has experienced directly or indirectly” (Landreth, 1991, p. 9). In addition, play allows children the opportunity to explore their challenges and difficulties. With the assistance of an able play therapist, in play therapy children play through and resolve troubling hurts, wounds, and experiences. Further, in the process of coming to trust the therapist, they come to trust themselves as unique persons with special abilities, talents and challenges (Landreth, 1991).

The last decade has seen a remarkable increase in the use of play therapy by school counselors to assist behaviorally and emotionally troubled children within the school environment (Campbell, 1993). One reason for this increase is that during this time period, the need for therapeutic intervention among pre and elementary school children has increased astronomically, while at the same time, there have been dramatic decreases in funding available for public mental health treatment services for children. Also, during this same time period, perhaps because of increasing demands from the classroom and society at large, greater than ever numbers of school principals and administrators appear to have been willing to embrace the clinical efficacy of play therapy and to include among the many duties of the school counselor, on-site counseling responsibilities with students (Campbell, 1993). School counselors appear to be increasingly called on to stem the tide of what at times seems a desperate need on the part of pre and elementary school children for behavioral and emotional assistance. Thus, it appears that for many children, their required therapeutic needs, if met at all, are most likely to be met in the school setting, through the work of the school counselor. However, despite their concerted

efforts, school counselors alone have difficulty managing all they are asked to do. It appears that a new model is especially necessary to make further training available to teachers so that they can meet the burgeoning emotional and behavioral needs of ever-growing numbers of children, especially those who are deaf and hard of hearing.

Filial therapy appears to be a logical choice for assisting classroom teachers in meeting the increasing emotional needs of their students, including deaf and hard of hearing students. Filial therapy, as conceived by Bernard and Louise Guerney in the 1960's, utilized parents as the primary agent of treatment. By instructing parents in child-centered play therapy skills for use with their own children, filial therapy initially enabled parents to become *therapeutic agents with their own children* (B. Guerney, 1964; L. Guerney, 1997; Landreth and Lobaugh, 1998). By receiving filial therapy instruction, the Guerneys believed that parents could be trained to be effective therapeutic agents to the extent that they could assist their children in recovering from traumatic events and developmental difficulties resulting in behavioral and emotional challenges (B. Guerney, 1964). First recommended by Axline (1947) and Moustakas (1959), the learned skills were to be practiced by parents with their child in weekly, 30-minute *special playtime* sessions at home.

The primary objectives of filial therapy are to assist parents in acquiring basic play therapy skills, to strengthen and enhance the parent-child relationship, and to help children reduce problem behaviors and internal emotional distress (L. Guerney, 1997). Working within a small group educational format, parents are taught by means of didactic instruction, hands-on, practical learning experiences, and emotional support from other participants and the leader. As new relational skills are learned and practiced in the *special playtime* sessions, parents are able to develop a different quality of emotional connection, a more accepting, empathic, and

nurturing presence with their children.

With the Guerney's primary thesis as his foundation, Landreth (1991) developed a modified, condensed, 10 week filial therapy model in which parents were trained in the use of primary child-centered play therapy skills with their own children. Costas and Landreth (1999) characterized filial therapy as: "Unlike more behaviorally oriented therapies, this model of therapy is not directed toward specific problems, but rather focuses on strengthening the parent-child relationship" (p. 3). The once a week special playtime sessions make it possible for the child to understand more completely the parents' behaviors, attitudes, and feelings toward the child and frees the child to express thoughts, feelings, and needs to the parents through the medium of play (B. Guerney, 1964; L. Guerney, 1997; Landreth, 1991).

When the parent is with a child during the special playtimes, the three primary empowering aspects of filial therapy are the parents' commitment to unwavering focused attention on the child, unconditional acceptance of the child's thoughts, behaviors, and feelings, and genuinely expressed empathy toward the child. With practice, filial therapy empowers parents to allow their children to take appropriate responsibility for their own (the children's) behavior and emotional growth. Instead of parents attempting to control children by means of fear or threat of punishment, filial therapy has been shown in clinical trials in a wide variety of settings to be an effective means for parents to free their children to be self-enhancing and self-limiting in age-appropriate ways, within the scope of the individual child's particular abilities and talents, and special needs and limitations (Bratton, 1994; Chau & Landreth, 1997; Costas, 1998; Glass, 1987; Glazer-Waldman, 1991; Glover, 1996; Harris & Landreth, 1997; Kale, 1997; Kott & Landreth, 1997; Lobaugh, 1991; Tyndall-Lind, 1999; Smith, 2000; Yuen, 1997).



Andronico and Guerney (1969) recognized that besides parents, teachers also had the ability to generalize to the classroom setting and their students the relationship skills that could be gleaned from filial therapy training. They recommended that filial therapy training consist of teacher trainees learning the skills of reflective listening, making comments to children that would build their self-esteem, reflecting back to children the meaning and intent of their feelings, and setting appropriate limits.

Guerney and Stover (1971) further expanded filial therapy to include the concept of using *teachers as therapeutic agents* with their students. As was done with parents, teachers were trained in the use of basic play therapy skills for use with their students. Although the research data from this project were anecdotal, the results appeared to be promising. Using the filial therapy model in 1978 to train college students as consultants, L. Guerney determined that filial therapy training was significantly effective in teaching relationship skills. Additional literature has further advocated the use of filial therapy training with teachers (Bratton & Landreth, 1995; Ginsberg, 1984; Landreth, 1999). Hence, training teachers to be therapeutic agents with their students has become an additional accepted therapeutic dimension of filial therapy.

Because research in the field of teacher education has shown that classroom teachers are typically not instructed in practical relationship building and communication skills with children, Brown (2000) investigated the effectiveness of the application of filial therapy he called Child-Teacher Relationship training (CTR) with undergraduate teacher trainees in a large university. Brown's study showed that Child-Teacher Relationship training facilitated positive change in the quality of teacher trainee's relational interactions with children, parenting attitudes, and play therapy attitude, knowledge and skills.

In the last five years, a further modification of filial therapy has shown notable promise

in training teachers to be therapeutic agents of change. White, Flynt, and Jones (1997); White, Flynt, and Draper (1999); Draper, White, and O'Shaughnessy, Flynt, and Jones (2001) have developed Kinder Therapy, or Kinder Training, as a means of using teachers, school counselors, or other school mental health professionals as therapeutic agents of change with their students. Kinder Training melds the work of the Guerneys and Landreth with central concepts of Alfred Adler's Individual Psychology to assist teachers and children in developing meaningful relationships (White, Flynt, & Draper, 1997; White, Flynt, & Jones, 1999; Draper, White, & O'Shaughnessy, Flynt, and Jones (2001).

If deaf and hard of hearing children are to develop a healthy sense of self and others, and utilize their native talents and gifts, they must be taught by teachers, educators, counselors, and parents who understand and respond to their specific educational and emotional needs as a part of their overall school/learning process (Elliott & Powers, 1988; Kalivoda, Higbee, & Brenner, 1997; Luetke-Stahlman & Luckner, 1991; Moores, 1996; Peterson & Siegal, 1997; Sass-Lehrer, 1983; Sass-Lehrer, 1986; Stoefen-Fisher & Balk, 1992; Winter & Van Reusen, 1997). The role of teachers and educators of deaf and hard of hearing children is critically important for the overall healthy development of the deaf or hard or hard of hearing child (Peterson & Siegal, 1997; Winter & Van Reusen, 1997).

In order to fulfill this role, teachers of deaf and hard of hearing children need additional training to enhance their ability as teachers to make a different quality of emotional contact with their students as part of their daily teaching regimen in the classroom. Teachers of preschool deaf and hard of hearing children need to become *therapeutic agents of change* as part of their role with students.

Further, in order to meet the deaf child's unique needs for assistance with the acquisition

of language, it is vitally important that preschool and early childhood teachers learn to relate with their deaf and hard of hearing students using the child's innate and most natural form of communication, play. Unfortunately, it appears that most current curricula for training teachers of deaf and hard of hearing preschoolers to make facilitative emotional contact with children do not necessarily include instruction in the child's most natural medium of communication, play and play therapy, as these precepts are taught in filial therapy training (Shroyer & Compton, 1992; Jones, Ross, & Kendall, 2001).

The reasons for using filial therapy with preschool teachers of deaf and hard of hearing children are two: the notable behavioral and emotional changes realized within parents and teachers who have participated in previous filial therapy research studies; and the demonstrated effectiveness of filial therapy to help establish relationships of trust, self-worth, confidence, and understanding between teachers and their students. Though no prior research studies of filial therapy have been done with deaf and hard of hearing children and their teachers, it seems a necessary and logical extension of earlier studies to do so.

#### Purpose of the Study

The purpose of this study was to determine the effectiveness of an adaptation of Landreth's (1991) 10-week filial therapy training model in increasing teachers of deaf and hard of hearing students: (a) empathic responsiveness with their students; (b) communication of acceptance to their students; and (c) allowance of self-direction by their students.

A second purpose of this investigation was to determine the effectiveness of an adaptation of Landreth's (1991) 10-week filial therapy training model as a method of intervention for deaf and hard of hearing preschool students. Specifically, this study was designed to determine the effectiveness of filial therapy in reducing students': (a) overall

behavior problems; (b) internalizing behaviors, including withdrawal, anxiety, and depression; (c) and externalizing behavior problems, including aggressive behaviors.

## Review and Synthesis of Related Literature

### Demographics of Deaf and Hard of Hearing Adults and Children

In 1999, the U.S. Department of Health and Human Services estimated that in the United States, more than 22 million people have hearing impairments ranging from hard of hearing to complete deafness (Holt, Hotto, & Cole, 1994; Schirmer, 2000). This number approximates 8.6 percent of the total U.S. population three years and older (Holt et al. 1994; Schirmer, 2000). Children under three years of age are not counted because the National Center for Health Studies does not collect data on this age group.

Estimates of severe and profound deafness range from .18 to .49 percent of the total U.S. population (National Center for Health Statistics, 1999). Of these, .10 percent are children who are profoundly deaf (Schirmer, 2000), while 1.8 percent of all children between ages 3 and 17 experience some degree of hearing loss (National Center for Health Statistics, 1999; Holt et al., 1994). Among school-age students ages 6 to 21 who received some degree of special education services during the 1996-1997 school year, approximately 1.3 percent were served under the disability category of hearing impairment (Schirmer, 2000). However, the number of students with some degree of hearing loss is undoubtedly significantly higher, since a number of these students were counted as having some other disability as their primary disability, according to the U.S. Department of Education (e.g., speech or language impairments, or learning disabilities). Shildroth and Hotto (1994), indicate that approximately 25 percent of deaf and hard of hearing students have *at least one additional disability*, while 9 percent *have two or more additional disabilities*.

Nationally, the prevalence of hearing impairment differs according to gender, as the overall prevalence is 10.5 percent for males and 6.8 percent for females. Though the gap widens after age eighteen, white males are more likely to be deaf and hard of hearing when compared to other age and ethnic groups (Holt et al., 1997). Compared to African-Americans, Caucasians are more than twice as likely to be deaf or hard of hearing, and Non-Hispanics are likewise, more than twice as likely as Hispanics to be deaf or hard of hearing (National Center for Health Statistics, 1994).

In Texas, the most recent statistics parallel the national statistics with some notable exceptions. Among deaf and hard of hearing children in Texas in 1999-2000, approximately 28 percent were six years of age or younger. While the national demographics for ethnicity hold when comparing African-Americans with Caucasians in Texas, the same is not true when comparing Hispanics with Caucasians. At present, the percentage of deaf and hard of hearing Hispanic children is greater than Caucasian children (42 percent Hispanic, 37 percent Caucasian).

This departure from the national norm is likely related to the fact that while the Hispanic population in Texas continues to increase dramatically, a disproportionate number of Hispanics live at or below the poverty level. The most recent U.S. Census Bureau figures reveal that the Hispanic population in Texas has increased from 25.5 percent in 1990 to 32 percent, while the Non-Hispanic Caucasian population has decreased from 61 percent in 1990 to 52.4 percent (*Dallas Morning News*, March 13, 2001, citing U.S. Census Bureau 2000 statistics).

The Texas state demographer notes that 60 percent of the overall population growth in Texas from 1990 to 2000 (up from 16.9 million to 20.8 Million) is accounted for by the increase in the Hispanic population, making Texas the second most-populous state behind California. In

the city of Dallas, Hispanics now account for approximately 35.5 percent of the city's total population. In 1990, Hispanics composed 21 percent of the population.

There can be no doubt that such rapid increases in population growth and diversification among ethnic groups have significant implications for those responsible for providing educational, social, and mental health services for the citizenry, and especially for children with special needs. However, some might consider deafness a low-incidence disability among children, even considering these increased population figures (Schirmer, 2000). Based on the prevalence figures alone, one might conclude that the problem of deafness and hard of hearing among children is less than serious when compared to the higher prevalence of other disabilities facing children entering the 21<sup>st</sup> century.

#### Emotional, Social, and Behavioral Challenges of Deaf and Hard of Hearing Children

Research findings support the position that deafness and the difficulties associated with hearing loss cause children, their families, educators, teachers, and social and mental health service providers challenges that have greater impact than mere prevalence figures imply (Luterman, 1999; Murdock & Lybarger, 1997-1998; Obrzut, Maddock, & Lee, 1999; Ziezuila & Harris, 1998). This is the case primarily because deaf and hard of hearing children encounter significant difficulties and delays with the acquisition of language and communication skills, including reading and writing, and emotional and social development (Greenberg, Kusche, & Spelz, 1991; Hindley, 1997; Katz & White, 1992; Kreimeyer & Antia, 1988; Lederberg, 1991; Loeb & Sarigiani, 1986).

Researchers have documented significantly higher occurrences of behavioral and emotional problems among deaf and hard of hearing children when comparing hearing and non-hearing school children (Greenberg et al., 1991; Hindley, 1997; Kalivoda, Higbee, & Brenner,

1997). In investigating behavioral and emotional problems among deaf students in mainstreamed school settings, Alpin (1987) found that 4.8 to 19.7 percent of students experienced emotional and/or behavioral problems. In the same study, he cited prevalence figures that were higher for deaf students educated in schools for the deaf (19.7 to 36.1 percent).

Van Eldik (1994) reported that deaf boys ages 6 to 11 showed a significantly greater percentage of behavioral difficulties, 28.4 percent to 23.2 percent, than hearing boys in the same age range. Hindley's (1997) study of behavioral problems among deaf and hard of hearing students indicated a prevalence range between 43 to 50.3 percent.

In this connection, Heller (1991, as cited in Maxon and Bracket, 1992), stated:

Young children with severe to profound hearing losses often have delayed social skills due to prolonged dependence and low self-control. Further, such children have difficulty developing an internal locus of control, experience social delays and isolation, and have more behavioral adjustment problems than peers with normal hearing (p. 133).

However, not all the research is so decidedly clear-cut in supporting Maxon and Bracket's (1992) beliefs. In fact, some results argue against the monolithic assertion that deaf and profoundly hard of hearing children always engage in higher levels of isolated or solitary play and lower levels of associative/cooperative play and have lower self-esteem. For example, while agreeing that deaf and hard of hearing children may be at risk for developing inappropriate social behaviors because of difficulties with communication, and subsequently because of fewer opportunities than hearing children to play and interact frequently and consistently with peers who can communicate with them, Antia and Kreimeyer (1997) found that deaf and hard of hearing children did not ignore or engage in one-sided interactions with their peers. When comparing the number of initiations and responses, the results revealed that the "...deaf and hard of hearing children engaged in balanced reciprocal interactions with their peers" (p. 68).

Researchers commonly agree that a confluence of factors likely causes behavioral and

emotional problems in deaf children. Still, certain factors appear to be more likely causes than others. A matter of considerable importance in this connection concerns the nature of the emotional and physical relationship between the deaf or hard of hearing child and his or her parents. As with hearing children, the quality of the emotional attachment between deaf and hard of hearing children and their mothers is essential in terms of the child's overall emotional development and well-being (Ainsworth, 1973, 1978; Bowlby, 1969, 1973, 1980; Greenberg & Marvin, 1979; Hagborg, 1995; Schirmer, 2000). The quality of the infant/early-child-mother attachment was judged a determining factor in the later emotional adjustment of deaf children in a study by Greenburg, Kusche, and Spelz (1991). They assert that the development of language is the critical element in the ability of a deaf child to develop internal motivation and external control. Building on Bowlby and Ainsworth's (1969, 1973, 1980; 1973, 1978) earlier seminal work with mothers and their young children in the *Strange Situation* paradigm, they further suggest that deaf children who use language for solving problems, either English or American Sign Language (ASL), demonstrate a higher degree of emotional adjustment.

It has been hypothesized that development of a normal mother-child relationship is disrupted by the inability of the child to understand the mother's usual means of communication (Harris, 1978; Moores, 1982; Schlesinger & Meadow, 1972; Wedell-Monnig & Lumley, 1980). Also, research suggests that hearing mothers of deaf 3 to 5 year olds are regarded as more intrusive, controlling, rigid, didactic, disapproving, and negative with their children than mothers of hearing children. Further, deaf preschool children have been viewed as less creative, responsive, happy, and positive with their mothers than were hearing preschoolers (Schlesinger & Meadow, 1972). Additionally, Meadow, Greenberg, Erting, and Carmichael (1981) determined that deaf preschoolers had shorter interactions with their mothers than did hearing



preschool children, and initiated interactions less frequently than did their hearing peers.

Bowlby (1969, 1973, 1980) and Ainsworth's (1973,1978) research suggests that security of attachment is related to the mother's sensitivity to the infant/toddler's needs and signals. In other words, the quality of mother-infant attachment is more related to the mother's ability to connect with the child than the child's particular characteristics or attributes.

Lederberg's (1991) findings combine with past research to suggest "the impact of hearing on mother-child interaction increases from toddlerhood to preschool. This change may be due to the increasing importance of language for normal mother-child interaction" (p. 12). As children become older (between 22 months and 3 years), age-appropriate activities become more dependent on language and good communication.

At this point, "child deafness begins to dramatically impact the quality of the mother-child interaction" (Lederberg, 1991, p. 13). Lederberg also noted that at age 3, but not before, deaf children communicated significantly less than their hearing peers. The communication of 3-year-old deaf children consisted of utterances that were characterized by signs and gestures. These children were also more likely to imitate their mothers at age 3 than their hearing peers were at 22 months.

Even though the quality of communication between mothers and their deaf children shifted when the child became 3 years of age, Lederberg's (1991) study found that the mothers of deaf children were *not* less responsive or emotionally less available to their children's communication or activities. However, the quality of their communication with their deaf children did change. The mothers verbalized less and signed and gestured more. They were more likely to initiate a new conversation than continue an old one. They touched their children more, repeated their communication much more, and used fewer positive utterances and more

attentional utterances than mothers of hearing children. Lederberg (1991) regarded these changes in interactional and communication transactions as ways in which mothers of deaf children were attempting to adapt to their child's delayed communication abilities, as opposed to a lack of caring or concern for their children. Mothers were struggling to find a more workable fit between their wish and need to communicate and the child's ability to focus attention on the communication.

In an attempt to discover causes related to behavior problems in deaf children, Kluwin (1985) studied referral forms in five schools for the deaf. The factor determined to be most predictive of disruptive classroom behavior was reading ability. Cohen's (1991, as cited in Schirmer, 2000) study suggested that the highest at-risk factors for behavioral problems among school age deaf children were student estrangement and alienation. This was so Cohen asserted, because even though estrangement and alienation are issues for all children during certain developmental periods, their issues are more likely to cause problems for deaf children because of their additional struggle with communication.

Some researchers have wondered whether deaf and hard of hearing children actually experience more behavioral or emotional problems, but are only misperceived to do so by parents and educators. A study by Murphy-Berman, Stoen-Fisher, and Mathias (1987) refuted this bias. Although communication difficulties between deaf and hard of hearing students and teachers not trained in American Sign Language (ASL) might be expected to lead to behavioral problems in students, research has not supported this contention. In fact, there seems to be a dearth of research that posits communication from teacher to child as a potentially causative factor in the development of emotional or behavioral problems among deaf children and adolescents. However, there is also a scarcity of research concerning communication from

teacher to child as a potentially *helpful* or *perhaps even a moderating factor* in the emotional and behavioral problems among deaf and hard of hearing children.

There is an abundance of research that indicates a higher incidence of depression among deaf and hard of hearing children and adolescents attending both residential deaf schools and public school programs (Watt, & Davis, 1991). In researching depression among deaf college students compared to hearing students, Leigh, Robins, Welcowitz, and Bond (1989) found a significantly higher level of mild, but not severe, depression among the deaf students. Among both hearing and deaf students, they discovered that perceptions of high maternal overprotection and low maternal nurturing and care were associated with depression. *However, when deaf students perceived a positive fit between their communication style and that of their parents and teachers, the deaf students appeared less likely to feel or describe themselves as depressed* (researcher's italics).

Luterman (1999) suggested that parental attitude related to the child's hearing loss is a key element regarding the emotional effects of hearing loss on the child. How the parent responds to the child's deafness greatly affects how the child comes to feel about his or her deafness or hard of hearing difficulty: "The emotional effects of deafness on the child are incredibly complex and can depend largely on how well the parents cope with the deafness and *on the educational methodology and setting that the child is exposed to*" (researcher's italics, p.78). For Luterman, the manner and setting in which the child is educated is a significant aspect of how well or ill the deaf child comes to accept and functionally adapt to his or her deafness. Implied in Luterman's (1999) assertion is an essential connection to the work of this research project, *that the quality of the emotional connection between the classroom teacher and the deaf*

*or hard of hearing child can be a critical factor in lessening the child's behavioral and emotional challenges in the school setting* (researcher's italics).

Additionally, Luterman (1999) emphasized the importance of the parents' attending to their own grief work regarding the child's loss of hearing or diminished capacity to hear. If parents do not allow themselves to grieve in this regard, the parents' unresolved grief issues may contribute to the child's negative feelings about self because of their deafness. Luterman advised a family systems approach to grief resolution, as other family members are also affected by the child's loss of hearing, and, therefore, by means of their response to the child's deafness, they hold some sway in shaping the deaf child's sense of self-regard.

For the child born deaf, Luterman (1999) suggested that the young child may experience no sense of loss because it is impossible to lose that which one never experienced. For this reason, some individuals come to view their deafness not as a pathological loss, but as a cultural deficit (see later discussion). However, on entering preschool and elementary school, especially in a mainstreamed classroom setting, the child can become acutely aware of his or her differences and experience painful isolation and depression, consequently developing a negative self-picture.

Bat-Chava (1993) reviewed twenty-two studies that compared the self-esteem of hearing and non-hearing children and determined that four key factors contribute to the self-esteem of deaf persons: hearing status (degree of hearing loss); family environment; *school and educational environment* (researcher's italics); and group identification. Bat-Chava's meta-analysis revealed that of these, perhaps the most essential element in the early family and school environment that affects the deaf and hard of hearing child's self-esteem, is the quality of the parent(s)' *and teacher's* (researcher's italics) emotional connection with the deaf child. Thus,

there is substantial research that documents the unparalleled significance of the parent(s)' and early childhood teachers' roles and opportunities to help to establish and enhance the deaf child's sense of positive self-regard and healthy emotional development (Harvey, 1989; Lederberg, 1993; Vernon & Andrews, 1990). The interventions proposed in this study will investigate the significance of the preschool teacher's role in responding to the deaf and hard of hearing child's social and emotional needs.

Research results further suggest that deaf children who are born to deaf parents tend to have higher self-esteem than deaf children who are born to hearing parents (Bat-Chava, 1993; Desselle, 1994, as cited in Schirmer, 2000; Cates, 1991; Clymer, 1995; Deselle, 1997; Loeb, & Sarigiani, 1986). One hypothesized reason for this finding is that deaf parents do not necessarily view their child's deafness as a hindrance that may condemn their child to a life of deprivation and struggle (Prendergast & McCollum, 1996; Rasing & Duker, 1993; Searls, 1993; Spencer, Bodner-Johnson, & Gutfreund, 1992; Warren & Hasenstab, 1986). Most deaf parents of deaf children use American Sign Language (or another form of sign language) with their deaf children as a primary way of relating physically and emotionally with the child, even before the child develops the ability to use language. Since deaf children have been shown to have the same cognitive capacity for the development of language as do their hearing counterparts, this earlier form of engagement and stimulation to develop language, combined with the parent's already-developed skill and comfort with communicating in sign language, tends to allow deaf children of deaf parents to enjoy more workable attachments at earlier developmental periods, when compared with deaf children of hearing parents (Schirmer, 2000). Especially when deaf parents view themselves as part of the Deaf culture and community, they are quickly able to furnish their children with a recognizable and valued place among other deaf individuals and

families (Bat-Chava, 1994; Dolnick, 1993; Glickman, 1996). Thus, the child is earlier afforded opportunities to develop language, social skills, and a sense of emotional well-being, with less struggle, and more consistency than is likely to be the case with deaf children born to hearing parents.

It appears to be the case that many hearing parents of deaf children have higher expectations that their children communicate orally than do deaf parents of deaf children (Schirmer, 2000). While this inclination is understandable, according to Kolod (1994), it countermands a fundamental precept of human attachment—that a common language is necessary for human beings to experience a sense of genuine connectedness with each other, and that the lack of a common language, or a less-than-fluent common language, will significantly impact the child-parent relationship. Two examples of this come to light if the hearing parent of a deaf child is not willing to learn sign language, or the deaf or hard of hearing child has not been able to learn to speak well orally. In both cases child and parent will not share a common language. As a result, their relationship will likely be impacted in a negative manner. However, this is not to suggest that hearing parents of deaf children do not or cannot share a common language with their deaf children. If parents are willing, they can learn American Sign Language or some other form of sign language.

Because deaf and hard of hearing children experience greater difficulty than their hearing counterparts in communicating their needs, wants, thoughts, desires, and feelings, they are likely to have somewhat lower self-esteem and less ability to show empathy to others. In addition, they experience higher incidences of depression, estrangement, aggression, anger, frustration, and impulsivity (Leigh, Robins, Welkowitz, & Bond, 1989; Luterman, 1999; Watt & Davis, 1991). These and other challenges make the task of educators, teachers, counselors, and caretakers of

deaf and hard of hearing children most difficult and therefore, worthy of further investigation.

### The Question of Deafness and Limited Hearing as Physical Disability or Cultural Distinction

Another factor that makes responding adequately to the educational, social, and emotional needs of deaf and hard of hearing children extremely difficult is related to the nature and study of deafness itself. Over the last one hundred years, the study and research of the problem of deafness and limited hearing has been fraught with controversy, dissention, and contention. Despite the pioneering work of earlier researchers such as Gallaudet and Le Clerc as well as the efforts of more recent investigators, attempts to arrive at a universally acceptable definition of *deafness* and *hard of hearing* (the current academically and socially acceptable terms in use) have failed (Schirmer, 2000).

The controversy turns around whether deafness and hard of hearing are to be understood as a physical disability, a pathological loss of hearing ability experienced at birth or later, or primarily a cultural difference that distinguishes some people from others. In current parlance, *deafness* and *hard of hearing* can be understood and defined *medically*, *educationally*, and *culturally* (Glickman, 1989; Katz & White, 1992; Schirmer, 2000). From a *medical perspective*, the terms *deaf* and *hard of hearing* are viewed on a spectrum of pathological hearing loss from *profound* to *slight* (DiPietro, Knight, & Sams, 1981; Harris, VanZandt, & Rees, 1997; Marshark & Clark, 1993; Murdock & Lybarger, 1997-1998; Myklebust, 1964). In this sense, *deafness* connotes loss and pathology, terms that could imply that deaf persons are incomplete, less than whole, and, by implication, worth less than hearing persons.

Understood from an *educational viewpoint*, *deafness* and *hard of hearing* are used to describe a child's ability to learn language by means of *audition* (hearing) and to *achieve*

*academically* (Kalivoda, Higbee, & Brenner, 1997; Schirmer, 2000). This usage is reflected in the Individuals with Disabilities Education Act (IDEA, 1973; 1991) in which *hearing impairment* is understood as a category of hearing loss severe enough to affect a child's educational performance in a negative manner (Schirmer, 2000; Stach, 1998).

From a *cultural point of view*, *deaf* and *hard of hearing* refer to a shared cultural identity that individuals use to define themselves (Dolnick, 1993; Glickman, 1996; Katz & White, 1992; Kluwin, 1994; Padden & Humphries, 1988). A primary example of this understanding is the way students at Gallaudet University in Washington, DC, perceive themselves. The premiere research university in the country regarding the issues of *deafness* and *hard of hearing*, Gallaudet students so view themselves as a community and culture of Deaf persons that they recently demanded and received a Deaf president as a concrete manifestation of their cultural unity. Describing this understanding of *deafness*, Schirmer (2000) states "...from a cultural standpoint, Deaf individuals do not view themselves as disabled" (p.5).

Attempts to differentiate between the three uses: *medical*; *educational*; and *cultural* can be challenging, even for informed professionals. Current usage mandates the use of the *lowercase d* when referring to medical or educational definitions of *deaf* (Katz & White, 1992). The *uppercase D* is akin to the usage that describes an individual according to their ethnic or cultural identity, just as one would speak of an individual as a German, Yugoslavian, African American, Christian, or Muslim (Glickman, 1996). The challenge for the researcher is to note the qualitative differences between deaf and hearing children in the language, cognitive, social, and emotional domains without deaf or hard of hearing connoting deficiencies as human beings.

A primary aim of this study will be to find meaningful ways to research and apply a variation of Filial Therapy (Guerney, 1964; Landreth, 1991) as a basis for training teachers of



deaf and hard of hearing preschool children to become therapeutic agents with their children, without diminishing the children or their teachers as persons. In this research project, for the purposes of clarity and simplicity, the researcher will use the term *deaf* to refer to children with profound hearing losses who have been medically diagnosed and determined by an early intervention program and Annual Review and Dismissal (ARD) committee to meet Dallas Independent School District criteria for *deafness*. In like manner, the researcher will use the term *hard of hearing* to refer to children who experience mild to moderate hearing losses. The researcher will *capitalize D* when referring to the cultural identity of deaf adults and children. Expanded definitions of these terms are offered in Chapter II.

### Physiological Processes of Hearing and Hearing Loss

While not a primary focus of this project, a basic understanding of the physiological processes of hearing and hearing loss are in order at this point. Another word for *hearing* is *audition*. Audition is the physiological process of collecting and interpreting sounds (Schirmer, 2000). The various parts of the ear gather sound waves from the environment and certain portions of the brain translate and interpret the sound waves into meaningful language (Stach, 1998). The intensity (pressure) of sound is measured in ratio units called *decibels* (dB). For each 10 dB increase in intensity, the ear perceives a tenfold increase in loudness of sound. Following the notion of ratios, a measured sound of 20 dB is 100 times more intense than a measured sound of 10 dB. The sounds of human speech range in intensity from approximately 20 to 55 dB (Stach, 1998). The frequency range (number of vibrations per second) of human speech is measured in units called *Hertz* (Hz). Higher frequency sounds are experienced by the human ear as having higher pitch than lower frequency sounds. Most spoken language occurs in the frequency range between approximately 500 to 2000 Hertz (Stach, 1998). Therefore, in order to

hear an individual must be able to perceive sound that ranges between 20 to 55 decibels and 500 to 2000 Hertz. The hearing range of children with normal hearing levels is from –10 to + 15 dB. Thus, a child with a hearing level measured between 16 to 25 dB would be judged to have a *slight* hearing loss, while a child with a measured hearing level of greater than 91 dB would be regarded as having a *profound* hearing loss.

According to Keith (1996), hearing loss is typically categorized with reference to its impact on communication. Based on audiometric testing without amplification, hearing loss is usually described as *slight*, *mild*, *moderate*, *moderate-severe*, *severe*, and *profound*. Regardless of the degree of hearing loss, researchers in the field advise that each individual child has a unique pattern of hearing even within these categories (Keith, 1996; Roark, & Berman, 1996). The child's ability to use in a functional manner his or her hearing varies considerably from individual to individual, a fact that has notable significance for teachers and educators of deaf and hard of hearing young children (Keith, 1996).

*Hearing loss* describes the process in which some part of the outer, middle, or inner ear is not functioning in a normal manner (Stach, 1998; Strauss, 1999). Hearing loss occurs both before and after birth. If a hearing loss is present at birth, it is referred to as a *congenital* hearing loss; if it occurs anytime after birth, it is called an *adventitious* hearing loss (Schirmer, 2000). If the hearing loss occurs before the child learns language it is termed a *prelingual* hearing loss; if it occurs afterwards, the hearing loss is called *postlingual*. According to the Commission on Education of the Deaf (1988, cited in Schirmer, 2000), approximately 95 per cent of school children experience prelingual hearing losses. By far the most common causes of prelingual hearing losses are premature birth and/or birth complications (8.7 percent of total). Heredity, maternal rubella, and cytomegalovirus account for virtually the remaining portion of prelingual

hearing losses, with cytomegalovirus supplanting maternal rubella in causing approximately 50 percent of cases (Schildroth, Rawlings, & Allen, 1989). Some believe that the statistics for cytomegalovirus may be artificially inflated, however, due to changes in reporting practices (Holt, Hotto, & Cole, 1994). Although cytomegalovirus can sometimes be detected through amniocentesis, at present it has no known treatment or prevention (Cunningham, Gilbert, Moaven, & Rawlingson, 1995).

RH incompatibility and complications during pregnancy are also causes of prelingual hearing loss. The Center for Assessment and Demographic Studies (1998) indicates that approximately 33 percent of prelingual hearing losses are attributable to unknown causes.

Most postlingual hearing loss in children is occasioned by meningitis (8.1 percent of total) and otitis media, according to the Center for Assessment and Demographic Studies (1998). While high fever, mumps, side effects from medications, measles, infection, and trauma after birth do contribute to postlingual hearing loss in children, approximately 60 percent of postlingual hearing losses are accounted for by unknown causes (Center for Assessment and Demographic Studies, 1998).

Prelingual hearing loss obviously has more serious consequences for children because the child has not been able to acquire language before experiencing the loss.

Thus, the implications for education and for the healthy and emotional development of affected children are more serious as well.

#### Evaluation of Play Behaviors as a Means of Understanding a Deaf or Hearing Impaired

##### Child's Cognitive, Emotional, and Social Functioning

A number of research studies have revealed an ongoing interest in using the play behaviors of deaf and hard of hearing children to evaluate the child's cognitive, emotional, and

social functioning. Play interactions among young children have been recognized as a significant component of normal child development (Cornelius & Hornett, 1990; Hartup, 1978; Higginbotham & Baker, 1981; Esposito & Koorland, 1989). Further, play has been linked to problem-solving, coping skills, and creative thinking, as well as the development of language (Johnson, Christie, & Yawkey, 1987). Cornelius and Hornett (1990) suggest that the quality and quantity of preschool children's play behavior is by itself a valid indicator of their development in terms of their language abilities, problem solving experiences, and sense of security.

Investigators have documented that the communication deficits of hearing impaired children inhibit normal play development (Higginbotham, Baker, & Neill, 1980). Several studies have shown that delayed verbal ability may "... restrict the emergence of cooperative make-believe play involving the use of objects and sophisticated peer interaction because verbal exchange appears to sustain such play" (Esposito & Koorland, 1989, p.1, citing Darbyshire, 1977; Garvey, 1974; Garvey & Hogan, 1973; Higginbotham & Baker, 1981).

The Higginbotham and Baker (1981) study suggests that hearing impaired children seem less able to engage in dramatic play activities than their normal hearing peers. Further, it appears that they engage in more constructive play than in adventurous games that make use of fantasy or imagination. While observing hearing impaired children in a play therapy setting, Sisco, Kranz, Lund, and Schwartz (1979) found that their play resembled that of hearing children two to four years younger. The authors' speculation was that while the hearing impaired children move through the same normal developmental sequences of play as their hearing peers, they do so at a slower pace because of their developmental language delays.

Terrell, Schwartz, Prelock, and Messick (1984) further investigated this deficit in symbolic play relative to age norms and found that the link between play and language is

apparently neither direct nor immediately causal. While still demonstrating severely deficient performance in the production of language, the language impaired children in this study demonstrated more advanced symbolic play than the normal subjects when the number of play schemas were used as the measure of evaluation. If the link between play and language were direct and causal, the language skills of these hearing impaired children should have been more advanced or consistent with their symbolic play behavior. Hence, this study suggests that the knowledge and concepts used in play are not always translated into verbal expression. Thus, while some aspects of language production and play evolve independently, still language impairment appears to be concomitant with a similar, though not equivalent deficit in symbolic play among deaf and hearing impaired children, and this deficit appears not to be connected with the child's chronological age.

Schirmer (1989) corroborated these findings in a study that investigated the relationship between imaginative play and language development. Schirmer found a direct correlation between language development and the child's use of planned pretend and story line. Schirmer's findings were consistent with earlier observations (Casby & Ruder, 1983; Casby & McCormick, 1985) that the development of imaginative play behaviors was not related to the hearing impaired, mentally retarded, or normal child's chronological age. While substantiating that profoundly and severely hearing impaired young children do engage in imaginative play, these play behaviors are related to the child's level of language development. In the Schirmer study, deaf and hearing impaired children who had arrived at later stages of language development showed higher levels of imaginative play, as demonstrated by higher percentages of time engaged in imaginative play and greater use of planned pretend play and story line. As these children were able to use multi-word expressions, they correspondingly also combined units of

play behaviors into sequences (story line). However, Schirmer's study also indicates that higher levels of language development and the ability to use imaginative play do not develop in parallel in deaf and hard of hearing children. For the children in this study, story line did not develop until they were able to combine three or more morphemes.

Bond (1987) compared the cognitive abilities of 40 hearing and 40 hearing impaired preschool children, ages 21/2 to 51/2. To analyze the differences between the hearing and hearing impaired groups of children, chronological age was treated as a continuous variable and also as the covariate in a one-way MANOVA. Results revealed no significant difference between the two groups. These results are meaningful because they furnish new information regarding the cognitive developmental abilities of hearing and hearing impaired children in this age group. Traditional measures of evaluating intelligence and cognitive development were not appropriate for the hearing impaired children in this study because they had virtually no verbal communication skills and minimal knowledge of and skill in the use of sign language. A modified and extended battery of nonverbal tasks was instead used. This battery had formerly been shown to be appropriate for use with autistic and mentally retarded children (Lancy & Goldstein, 1982). While the hearing impaired children lagged slightly behind the hearing children on all of the tasks, the developmental trends in both groups were the same. This study suggests that when preschool hearing impaired children are tested appropriately, using nonverbal rather than verbal tasks, their performance has been shown not to differ significantly from their hearing peers, even on measures of critical preoperational abilities. Thus, despite their linguistic deficits, hearing impaired children perform at the cognitive level one would expect on the basis of their chronological age.

### Play Therapy Intervention with Deaf and Hard of Hearing Children

Although play therapy has been a part of the therapeutic scene for almost 100 years, it is only within the last 30 years that it has moved to the front as the treatment of choice for children requiring therapy (Gil, 1991; 1994; James, 1997; Landreth, 1991). Sigmund Freud (1955) is known to have used play therapy in the oft-mentioned case of Little Hans and his father. Freud effectively involved the father of a phobic 5-year-old in the treatment of the child by instructing the father as to how to respond to the child's play. As father of the child patient, Freud regarded the father's unique relationship with the child as being paramount to his ability to interpret the child's remarks. Freud deemed the father's bond with the child as essential to the successful treatment outcome.

According to Gil (1994), the work of Hug-Helmuth in 1919 marks the first documentation of the use of play as a modality of therapy as part of psychoanalysis with children. However, Anna Freud (1928; 1948; 1964) and Melanie Klein (1959) are generally recognized as the prime instigators of the use of play therapy in their psychoanalytic work with children. Jacobs (1949) advocated home play sessions between parent and child for the purpose of building more effective parent-child relationships. Carl Rogers encouraged his daughter (Fuchs, 1957) to use regular play times with her child. Fuchs judged the playtimes to be an essential vehicle in helping her daughter overcome negative emotional responses to toilet-training difficulties. Along with resolution of her daughter's difficulties, Fuchs also experienced positive changes in herself.

Child-centered play therapy emerged from of the earlier work of Carl Rogers' (1951) conception of person-centered therapy. According to Landreth (1991), Virginia Axline (1947), former student and later colleague of Rogers, is generally credited with formulating the

principles of child-centered play therapy by elaborating Rogers' principles of client-centered therapy. Central to Axline's (1947; 1969) approach to play therapy is the position that the primary focus of the play therapist is *being with* the child, rather than *doing for* or *doing to* the child (Landreth, & Sweeney, 1997). Haim Ginott (1961) and Clark Moustakas (1959; 1992) added to Axline's work, from which came the unique theory and methodology of child-centered play therapy, a therapy that has been shown to be appropriate for, and to have demonstrated clinical effectiveness with, a wide range of diagnoses and difficulties (James, 1997).

Despite the assertion of James and others as to the clinical efficacy of play therapy with children, some have criticized play therapy as ineffective because of a lack of an acceptably large research base (Lebo, 1953; Levitt, 1957; 1963; 1971; Phillips, 1985; Reade, Hunter, & McMillan, 1999). To address this issue, Bratton, Ray, Rhine, and Jones (2001) conducted a meta-analysis of 94 research studies that were based on play therapy, filial therapy, or a combination of play and filial therapy. The meta-analysis established that play therapy appeared to lead to significant positive treatment outcomes in therapy with children. The positive effects were demonstrated across age, gender, modality, setting, and theoretical frames.

Historically, play itself has long been regarded as essential to the healthy emotional and physical development of children across educational, developmental, and clinical domains. Erikson (1963) characterized play as an "emotional laboratory in which the child learns to cope with [his or her] environment" (p. 4). Axline (1947, 1969) is reported to have described toys as the words and play as the language of children, a phrase that has captured the essence of the play therapy experience world-wide.

When considering how children develop, to regard play as children's primary language of expression is logical and understandable. Children are chiefly concrete thinkers prior to age 10



or 11, conceptualizing and expressing themselves more readily through concrete actions than expressive language (Landreth, 1991). Landreth (1991) further characterizes play as the symbolic language of self-expression for the child, an emotionally and physically safe way in which children can symbolically express the “internal conflicts, emotional turmoil, and uncertainties that are within them” (p.10). Still further: “Play is to children what verbalization is to adults. It is a medium for expressing feelings, exploring relationships, describing experiences, disclosing wishes, and achieving self-fulfillment” (Berg & Landreth, 1990, p. 261).

In the child-centered approach to play therapy, the relationship between child and therapist is viewed as the central aspect of the therapeutic process that facilitates and enables positive growth and change in the child (Axline, 1947; Ginott, 1961; L. Guerney, 1983; Landreth, 1991; 1997; Moustakas, 1959). The relationship between child and therapist is unlike any the child has experienced with an adult. Within an atmosphere of unconditional acceptance of the child as he or she is, yet within the safety of the physical bounds of the playroom, and with limits set as necessary to assure child and therapist safety, the child is free to use the available toys in ways that will naturally access and allow meaningful expression of the child’s emotional wounds and developmental struggles, as well as wishes, needs, and fantasies. Landreth (1991) captures this unique relationship in these words: “The play therapist’s objective is to relate to the child in ways that will release the child’s inner directional, constructive, forward-moving, creative, self-healing power” (p. 17). Whereas direct expression of feelings related to traumatic experiences is likely too overwhelming or frightening for the child, within the safe bounds of the unique therapist-child relationship, play affords the child naturally accessible, yet manageable ways to work through experiences that are potentially emotionally crippling for child. Within

this context, the child “strives to master perplexing confusions, conflicts and skills for living in the grownup world” (Frank, 1955, as cited in Landreth , 1982, p.24).

Thus, play therapy is not just one technique of intervention among others used by therapists to heal the child of diagnosed psychopathology. Child-centered play therapy is, rather, a philosophy that emerges from a larger world-view in which the relationship between therapist and child has primacy over prescribed procedures and techniques for change.

Child-centered play therapy encompasses a belief in the innate tendency and capacity in every child to grow in the direction of his or her own creative inner tendency toward healing and wholeness, given appropriate opportunities of environment and relationship. Hence, the child is not perceived as “broken, in need of fixing” by someone outside themselves. In child-centered play therapy, the focus is on the process of developing an abiding relationship between the child and therapist, with the therapist assuming a role akin to midwife in birthing what already exists within the child in a primordial, undeveloped form. The child’s emerging sense of a new and more capable and actualized self unfolds from within the child by means of, or through, the ongoing relationship of unfaltering trust in, and unconditional acceptance and honoring of the person of the child by the play therapist.

The goal in child-centered play therapy is for the therapist to apprehend, even to revere in a genuine way the child’s internal world-view, the child’s perception and experience of his or her world. By means of the therapist’s empathic acceptance of the child’s perceptions and experience, and also communication to the child of such empathy and acceptance, the child comes over time to accept and revere his or her own unique perceptions and experience. Hence, for the child, parts of his or her self or experience in life that formerly have had to be disowned, repressed, or acted out in some form, can gradually begin to be owned and integrated into the

child's abiding sense of self and other. Relying on the person of and relationship with the therapist, and the therapist's unshakable expressions of belief in the child's innate sense of worth and goodness, the child comes to integrate into his or her core sense of self the therapist's picture of him or her. This ongoing, dynamic process proceeds along its own lines, with the child most often taking the lead, and the therapist following, using the facilitative skills of tracking play behaviors, reflecting feelings implicit in the child's play behaviors, and setting appropriate limits as required to insure the safety of both the child and therapist, as well as the toys and playroom itself.

#### Use of Play Therapy in the Training and Education of Teachers of Deaf Children

With very few exceptions, research studies of the use of play therapy as the modality of choice for use with deaf and hard of hearing children are virtually non-existent. As mentioned earlier, Oualline's (1975) study found that when 4 to 6 year old deaf children who had been identified as having behavioral problems participated in 10 individual child-centered, nondirective play therapy sessions, they evinced a significant increase in mature behavior patterns as measured by the *Vineland Social Maturity Scale*, as compared with children who experienced 10 weeks of individual free play. However, the same children failed to achieve significance on measures of total personality adjustment and behavior patterns as shown on the *Behavior Problem Checklist* and the *Child Behavior Rating Scale*. One difficulty with the Oualline (1975) study may have been the lack of common language shared by therapist and child. Without an interpreter present during the play therapy sessions, and without knowledge of sign language, the therapist was left to guess at the meaning of the child's verbal utterances accompanying the nonverbal play behaviors. But perhaps more significantly, there could be little assurance that the child was able to understand the therapist's reflective, facilitative verbal

responses to the child's play. Still, the therapist was apparently able to connect emotionally with the children from the experimental group, despite the obvious hindrances to unencumbered communication.

A South African study (De Wet, 1994) recounts the usual list of behavioral, emotional, and social difficulties evinced by deaf and hard of hearing children, especially in an educational setting, that are known to result from difficulties with language, speech, and communication. Among those enumerated by De Wet are poor communication, excessive dependency, impulsivity, difficulty in developing appropriate empathy, irritability, low self esteem, temper tantrums, depression, and distrust. In order to decrease the high risk of misdiagnosis both psychologically and educationally, De Wit recommended the modification of language in the testing instruments. Also, it is recommended that the therapist understand the etiology of the child's hearing loss, his or her underlying family dynamics and personal psychodynamics, as well as educational assets and needs. In terms of therapy with the deaf or hard of hearing child, De Wet suggested that play therapy is especially suitable because it makes use of the child's ability to move freely about the play room and visualize and imagine what can be done with the available toys. Also recommended for use with deaf and hard of hearing children are art and drama therapy as well as theraplay.

A study at Temple University (Cohen, 1987) evaluated the effects of adding a short-term parent counseling component to a comprehensive early intervention program for young deaf children. It was thought that counseling would have significant effects on family functioning. Results showed that adding the counseling component did in fact have significant positive effects on the family environment. Parents who received counseling in addition to the standard program services reported less conflict, fewer family and parent problems, less behavioral and

attitudinal problems in the deaf child, greater family support, and more open communication within the family. While the project did not make use of filial therapy to train parents in the use of play therapy relational skills with their children, according to research literature, it was the first empirical research on counseling for parents of young deaf children which has demonstrated that such counseling had significant positive effects across a number of dimensions of the family environment. Again, it seems that training teachers to be therapeutic agents of change by teaching them basic play therapy relational skills for use with their own students, as this research project proposes, warrants further investigation.

A survey of teacher education and training programs for deaf and hard of hearing preschool children reveals that play therapy relational skills are not a significant portion of current curricula. Shroyer and Compton's (1992) survey of recent literature indicated that some teacher education programs for deaf and hard of hearing children have advocated "greater emphasis on the arts, sciences, and humanities" (p.416), as well as expressing concern about "the lack of a strong knowledge base relative to teacher preparation in deafness" (p. 416-417). Shroyer and Compton recommend that other deaf education programs consider implementing a reworked teacher preparation program for deaf and hard of hearing children that was developed at the University of North Carolina at Greensboro. Students there are now required to take classes in traditional liberal arts categories as well as education and teacher preparation courses. All primary and secondary school majors must also select a second major or a concentration in addition to their first major. Students majoring in the education of deaf children may select one of three areas of specialization: preschool; elementary; or secondary. In addition, teachers must also meet state teacher certification requirements, including courses in general psychology, the institution of education, and the psychological foundations of education. For all its merit in

attempting to broaden the educational base and general cultural appreciation of its teacher trainees and to shore up the trainees knowledge of the processes related to deafness in children, no mention is made of training teachers to be therapeutic agents with their children. No course is included that instructs teachers as to how to relate emotionally with their students in the students' most natural medium of communication, play. No effort is made to bolster the teachers' ability to relate to deaf children who exhibit problem behaviors by using basic play therapy skills to do so.

A review of inclusion strategies for deaf students with special needs by Gallaudet University for the American Society for Deaf Children recommended modifications of traditional school and classroom structures and procedures, including the implementation of specific teacher behaviors (Jones & Ross, 2001). These behaviors include emphasis on natural consequences as outcomes of inappropriate behavior, rather than teacher-controlled consequences. The goal is to teach deaf students to become more responsible for their behavior and its results. While emphasis on allowing students to accept the natural consequences of their behavior sounds akin to the filial therapy strategies of giving choices and setting limits, the process is not part of an overall program of enabling teachers to meet students on their own terms, using play to relate emotionally with students. The suggested interventions of this research project will address the deaf and hard of hearing student's need to be reached by the classroom teacher at the point the student is most able to communicate thoughts, feelings, needs, and wants, the point at which significant change in the student's behavior is more likely to occur, play.

### Filial Therapy

*Filial Therapy* was originally conceived by Bernard Guerney (1964; 1969; Guerney,

Coufal, & Vogelsong, 1981; B. Guerney, L. Guerney, & Andronico, 1966; B. Guerney, L. Guerney, & Stover, 1972) as an intervention for helping parents use aspects of child-centered play therapy as a way of strengthening and enhancing the emotional relationship between parents and their children. Lousie Guerney (2000) recounts “five major arguments” (p. 2) that furnish support for Bernard Guerney’s filial therapy approach: (a) most children do not need therapy because of the parent’s pathology, but rather because of the parents’ lack of effective parenting knowledge and skills; (b) assuming a “therapeutic role” should enable parents to relate more appropriately and positively with their children and vice-versa, because the parent’s new interactional manner of engaging the child will likely disrupt the former dysfunctional cycle of engagement, as well as allow the child a more acceptable venue to communicate thoughts, feelings, and needs through the medium of play; (c) though the Rogerian (Rogers, 1951) tradition in counseling had already advocated that parents hold regular play sessions with their children, two of the leading exponents of Rogers’ theories, Baruch (1949) and Moustakas (1959), had not provided a systematic training or supervisory format for parent training; (d) by regarding (in effect “baptizing”) parents as positive “change agents,” parents would no longer feel that they had “failed” at some aspect of child-raising, and would, therefore, be supportive and helpful, rather than resistive, to the process of change; (e) the model builds on the natural, significant, and already existing bond between parent and child, assuring that positive changes made within this relationship will have more far-reaching impact than those made in a therapist-child relationship. Bernard Guerney also viewed filial therapy as furnishing an answer to the need to provide mental health services to increasing numbers of parents and children.

B. Guerney (1964) regarded filial therapy as a “preventive measure and as a method of building a foundation in childhood for better mental health and self-realization in adulthood” (p.

343). In filial therapy parents are trained by therapists in the strategies and skills of child-centered play therapy as practiced by Axline (1969), Ginott (1965), and Moustakas (1959). According to Landreth and Lobaugh (1998), the objective of filial therapy is to enable the parent to become a “*therapeutic agent* in the child’s life by utilizing the naturally existing parent-child bond, hence the term *filial* therapy” (p. 158). “Filial therapy enhances the relationship that already exists between a parent and child by facilitating the development of empathy, genuineness, and acceptance on the part of the parent in weekly 30-minute play sessions” (Costas, 1998). These conditions help the child to acquire a new perception of the parent as ally. In addition, “this new creative dynamic of empathic responding...becomes the creative process through which change occurs *within* the parent, *within* the child and *between* parent and child” (Landreth, 1991, p. 339).

In describing filial therapy, Lousie Guerney (2000) states:

The premise of FT (filial therapy) was that despite some psychological shortcomings, most parents have within them the psychological and emotional wherewithal to make a major contribution to the positive development of their children, given knowledge and practice, and emotional support to do so (p. 7).

#### Use of the Term *Filial* in Filial Therapy

Some have regarded the term *filial* as obtuse or at least confusing and have deemed B. Guerney’s choice of the word *filial* in filial therapy as a stumbling block to understanding in terms of its *de facto* purpose and use. Guerney (2000) indicates that the name *filial therapy* was selected because of what she describes as the literal meaning of *filial*: “...of or pertaining to a son or a daughter in relation to the parent” (p. 4). According to Merriam-Webster (1983), *filial* means “of, relating to, or befitting a son or a daughter” (White, Flint, & Draper, 1997, p.462).

A more in-depth investigation suggests that *filial* is ancient Greek in its root form, and



likely derives from the Greek word *philos*. The original meaning of *philos* appears to have been, as an adjective in its passive form, “beloved, dear,” and in its active form, “loving, kindly disposed, devoted” (Arndt, & Gingrich, 1952, p. 868). The term may also have originated from the verb *phileo* which carries the meaning of “to love, have affection for, like...” when referring to another person (Arndt et al., 1952, p. 866). At times *philos* was combined with the word for child (*tekno*) to form *philoteknos* which became a special word connoting a child held in high regard referred to in a familiar loving manner. The diminutive of *tekno* (*teknion*) implied extra affection and endearment, as in “little child” (Arndt et al., 1952, p. 815). Hence, *philos* and *philoteknos* came generally to refer to being and acting in ways that could be construed as being “loving of one’s children” (Arndt et al., 1957, p. 869.)

It appears likely that some English transliteration of these terms and their meanings lies behind and informs the current English definition of *filial* as it has come to be used in the term *filial therapy*. Thus, B. Guerney’s choice of the word *filial* appears to be generally accurate with reference to its application to filial therapy, but *filial* is not a commonly used word in modern English and it appears to furnish little by way of a description or understanding of its actual meaning when combined into the term *filial therapy*.

Moustakas (1959, 1992) also advocated that parents use traditional play therapy as a model for at-home regular play sessions with their children. Moustakas viewed play therapy as having unique possibilities for empowering parents to enter their child’s world on the child’s, rather than the parent’s terms. Staying true to a fundamental play therapy precept, Moustakas regarded the parents’ use of play therapy with their own children in the home as primarily being about the relationship between parent and child. Moustakas recognized that it was within the confines of this relationship that the child could become uniquely him or herself. “Play therapy

in the home is essentially a relationship...through which the child discovers himself...opens himself up to emotional expression and in the process releases tensions and repressed feelings” (Moustakas, 1959, p.275). Further, Moustakas (1992) was aware that if parents were able to respond with genuine empathy for their children in the play sessions, this acceptance and valuing process had the capacity to establish and strengthen their child’s inner sense of well-being as few other parental encounters could. Joining with the child through the child’s most natural means of communication afforded parents a glimpse into their child’s heart of hearts in a manner that was neither threatening nor overwhelming to the child. In fact, the parent’s genuine acceptance and empathy of and for the *person* of the child, enabled parents to see their child as a valuable and worthwhile person, as opposed to a constellation of problems or symptoms.

An increasing number of research projects have established filial therapy as a viable clinical treatment of choice, a type of early intervention, and a preventive measure when working with children whose difficulties range from normal to severe maladjustment. According to Smith (2000), a summary of the empirical research can be categorized into a number of primary areas of filial research. A modification of these areas will be offered here. Among the categories are: the efficacy of filial therapy with children with different types of emotional, symptomatic, and behavioral problems; the efficacy of parents as therapeutic agents of change with their children; the effectiveness of methodology and integration of essential components of the model; the efficacy of strengthening the child-parent relationship and efficacy of parents as therapeutic agents versus professionals and paraprofessionals; the efficacy with unique populations of families living with at risk factors and difficult life circumstances. A final added category is the effectiveness of teachers as therapeutic agents of change with their students.

### Filial Therapy with Various Child Presenting Difficulties and Diagnoses

Filial therapy has been shown to be an efficacious alternative clinical intervention for children with a wide variety of normal developmental and adjustment problems, behavioral and physical difficulties, clinical diagnoses, and traumatic events.

Andronico and Blake (1971) investigated the effects of filial therapy with parents of children with stuttering problems. They discovered that the child's stuttering abated when the parents changed their interactional pattern within the child's environment and were able to inhibit their prior pattern of pressuring or interrupting the child. Gilmore (1971) investigated the effects of filial therapy with children diagnosed with learning disabilities. He determined that the parents' use of learned play therapy relational skills was the key factor in improving their children's academic performance, self-esteem, and social functioning. Measures of family interaction improved as well.

In a meta-analysis of 60 clinical cases, Hornsby and Applebaum (1978) discerned that filial therapy was noted to be clinically effective with children treated with a broad spectrum of initial diagnoses. The diagnoses included a handicapped child, a parent and child in conflict, and a borderline psychotic child. The authors noted significant improvement in the children's behavioral difficulties and in child-parent relationships.

Louise Guerney (1979) researched the efficacy of filial therapy among parents of children diagnosed with disorders that were chiefly organic in nature. The range of disorders included attention deficit/hyperactivity disorder, physical disabilities, learning disabilities, and mild mental retardation. Along with their primary clinical presentation, the children also struggled with secondary adjustment problems. L. Guerney's choice of subjects was precipitous in that research in the field has shown that children experiencing physical disorders are likely

also to experience low self-esteem, excessive dependence on parents, a high degree of impulsivity, and a general lack of self-control. Guerney noted that the children whose parents received filial therapy training were judged to have shifted from negative to positive feelings about themselves and others, developed a higher degree of self-control, and realized greater independence when compared to the control group. The changes merit additional significance when it is noted that the scores on the developmental factors evaluated in the experimental group were compared to the scores of a control group composed of children who had no diagnosed behavioral or physical disorders.

In a recent dissertation study, Kale (1997) used Landreth's 10-week filial therapy model to study the effects of filial therapy with children with learning disabilities. Both Kale's experimental and control group participants were parents who had children diagnosed with learning differences. Results revealed that the parents receiving filial therapy training demonstrated a significant increase in acceptance of their children, as well as a significant reduction in the stresses arising from parenting as compared to the comparison group. Results of Kale's study were regarded as worthy of further mention because, although the empirically verified level of parental stress is very high for parents with learning-disabled children, parents receiving filial therapy training reported a reduction in parental stress levels.

#### Evaluating Parents as *Therapeutic Agents of Change*

The late 1960s and 1970s witnessed a shift in emphasis in filial therapy research. The emphasis centered on the assessment of parents' abilities to adapt to the role of *therapeutic agents of change* with their own children. More specifically, researchers focused on investigating whether parents could functionally enable their own children to make significant and lasting changes as a result of their participation in filial therapy training. Hence, many studies focused

on the identification of the types of changes children could make following their parent's filial therapy instruction.

One of the first of such studies was carried out by B. Guerney and Andronico (1967) on the use of filial therapy training in schools. In addition to a positive increase in parent's willingness to participate and sustain interest in their children's therapeutic treatment, the researchers noted a significant decrease in parental blaming of the school for the children's difficulties. B. Guerney and Andronico (1967) also noted that the parents felt less helpless and more empowered to enable meaningful and positive change in their own children, following the filial therapy training.

Stover and B. Guerney (1967) determined that mothers who received filial therapy training significantly increased the number of reflective statements in their parent-child interactions, while at the same time, they decreased the number of controlling and directive statements in these interactions. Stover and Guerney were convinced that these positive shifts in the mothers' transactions with their children translated into positive influences on their children's behavior. Thus, as the mothers amended the ways in which they interacted with their children, the positive changes trickled down to their children's more typical daily behavior. No similar changes were noted among mothers who did not participate in the training.

By working with a much larger group of 51 mothers and their children, in 1971 B. Guerney and Stover reconfirmed and strengthened the results of their 1967 study. Analysis of the results revealed that mothers could in fact be trained to allow their children self-direction, accurately reflect their feelings, and connect emotionally in meaningful and facilitative ways with their children, following filial therapy training. Other changes reported by parents were more reciprocal interaction with their children, increased levels of independence and connection

with their children apart from the special playtime sessions, and increased positive changes in the children's behavior.

Because B. Guerney and Stover (1971) did not employ a control group in their study, Oxman (1972) determined to bolster the research and statistical design by matching on designated variables a control group of volunteer parents with parents in the study. Matched variables included socioeconomic status, geographical location, size of family, and parents' and children's ages. Positive improvements in the children's behavior were reported by the experimental group parents, while control group parents noted no changes in their children's behavior.

In 1975 a longitudinal qualitative follow-up study of 42 participants in the B. Guerney and Stover (1971) study was conducted by L. Guerney. One to two years following termination of treatment, results confirmed that 32 of the parents continued to report improvements in their children, while as few as three of the original 42 participants were receiving some form of professional treatment at follow-up.

Sywulak (1979) investigated the long-term efficacy of filial therapy training with parents of emotionally disturbed children 10 years of age and younger by designing a research study that used children as their own controls. Participants received four months of filial therapy training, after first going through a four-month waiting period during which they functioned as their own controls. Collection of data took place at four intervals: at intake; at the initiation of training; two months into training; and following four months of training. Significant results were obtained with regard to improved child behavioral adjustment and enhanced parental acceptance. In addition, withdrawn children who participated in the study were found to change faster than aggressive children who participated in the study.

Using 19 of the families from Sywulak's (1979) investigation, Sensue (1981) conducted a follow-up study and determined that there were no significant reductions in adjustment among participants. Further, children who had made positive increases in adjustment in the Sywulak project, maintained them at follow-up. To enhance statistical efficacy, Sensue (1981) formed a matched control group on the variables of education, socioeconomic status, age, gender, as well as having children judged to have normal behavior aside from usual childhood behavioral adjustment difficulties. Results indicated that the children who participated in the study maintained the gains achieved during the first study. There were no notable decreases in post-treatment.

Effectiveness of Methodology; Efficacy of Strengthening the Parent-Child Relationship;

Effectiveness of Parents Versus Professionals and Paraprofessionals as *Therapeutic*

*Agents of Change*

In the 1970s, the focus of research in filial therapy began to include the design of the model itself to discern if there were aspects of the instructional methods used that could be determined to contribute to its effectiveness and if aspects of other therapeutic modalities could be integrated into the filial therapy model and vice-versa. In addition, researchers began to investigate the impact of filial therapy on changes in the child-parent relationship. Further, in the eighties researchers began evaluating parental effectiveness (after receiving filial therapy training) compared to paraprofessional and professional effectiveness in using filial therapy as a treatment of choice with children.

Comparing his variation to B. Guerney's (1964) original model of filial therapy, Boll (1972) investigated the effects of adding the behavioral components of teaching reinforcement and extinction techniques to participants. Boll used three groups of randomly-assigned mothers

of educable mentally retarded children and assigned them to three experimental conditions: a traditional filial therapy group as described by Guerney (1964); Boll's variation taught by an expert, adding reinforcement and extinction techniques to Guerney's conceptualization; and a control group that received no filial therapy intervention. Parental participants in Guerney's traditional filial therapy group model reported the highest improvement in their children's socially adaptive behavior. Also, mothers who participated in both versions of filial therapy groups indicated increased social improvement in their children as compared to participants in the control group. Further, Boll noted that members of the traditional filial group reported closer relationships with their children when compared with the other two groups.

Wall (1979) designed a study to compare parents trained in filial therapy with graduate therapist-trainees trained in filial therapy, then compared these with a control group that was not given filial therapy training. The most significant changes in the children's positive emotional adjustment were noted among the parents trained in filial therapy, when compared with the other two groups. Children whose parents received the training were judged to exhibit more positive adjustment related to the expression of negative emotions and increased perception of positive attitudes within their families. According to Wall, the children's increased positive adjustment was likely the result of the parents' increased ability to relate empathically with their children.

A study in which parental and paraprofessional groups received 12 weeks of training in filial therapy, and a control group received none, was conducted by Payton in 1980. Results revealed notable improvements in both children's behaviors and parenting attitude when compared with the other two groups. Also, parental participants were shown to have more impact on their children's personality adjustment than either the paraprofessional or control group parents.



In 1980 Kezur investigated the impact of filial therapy training on the communication patterns between mothers and their children. Experimental group mothers were given filial training at the same time their children were in play therapy sessions with trained therapists. Along with significant improvement in the self-esteem of both the children and mothers, Kezur noted post-test improvement in the mothers' communication and relational skills as well. Kezur (1980) also reported that those children who vented anger and aggression toward their mothers in the play therapy sessions were judged to be more communicative and open with their mothers in the parent-lead play times. In addition, mothers who reviewed videotapes of the play sessions with their children, and received feedback from the trained leader as part of the process, were judged to be the most adept at implementing the filial relational skills with their children.

Dematatis (1981) compared the addition of a variation of Kagan's Interpersonal Process Recall training to filial therapy training, with the traditional filial therapy model of Guerney (1964). Dematatis reported that parents who received traditional filial therapy training related more effectively and therapeutically to their children than the filial therapy group with added videotaped recall with affect simulation (per Kagan). The addition of Kagan's IPR components did not significantly affect the quality of measured parent-child interaction when the groups were compared.

Lebovitz (1983) compared the effectiveness of three groups: a mothers' group receiving filial therapy training; a mothers' group receiving no filial therapy training, but receiving supervision of play sessions; and a control group of mothers receiving no training or treatment of any kind. Independent observers, teachers, and parents assessed the mothers' learned therapeutic skills. Results revealed that the mothers in the traditional filial therapy group showed increased positive involvement with their children, communicated greater acceptance of their children's

feelings, and allowed their children more self-direction in the practice play sessions, as compared with the other two groups. Lebovitz also noted that children of mothers in the traditional filial therapy training group demonstrated significantly less aggression, withdrawal, and dependence, along with the mothers' reported perceptions of fewer problem behaviors. Conversely, control group children evinced the least change, while their mothers perceived them to have the greatest number of problem behaviors.

Glass (1986) studied the efficacy of using filial therapy to train parents to become *therapeutic agents of change*. The Glass study appeared to suggest that filial therapy could be an effective intervention for also increasing feelings of closeness within the parent-child relationship, while at the same time preserving the necessary structure of parental authority. An additional positive aspect of the filial therapy training was that the family dynamics were altered in a positive direction. This positive influence was especially noted in the family dynamics dealing with control, conflict, independence, and expressiveness.

Packer's 1990 case study also posited notable positive changes in family dynamics subsequent to parental participation in filial therapy training. Significant positive shifts in the relative balance of the father-mother-child triad were demonstrated in Packer's research. Following filial therapy training, the fathers were perceived as exercising more authority within the triad, especially by the mothers who had heretofore been viewed and viewed themselves as being primarily responsible for the entire parenting function within the family unit. The mothers appeared more willing to share the power and control of parenting with their husbands, thereby significantly shifting the balance of power in the family and allowing the fathers to share more of the nurturing function of parenting as well. The inclusion of the fathers as equal-opportunity parents with the mothers was thought to account for the parents' new picture of themselves, such

that each could enable positive changes in their children. As both parents began to visualize themselves as more capable parents, the children of the parents receiving filial training were noted to demonstrate an increasing ability to manage their own emotions, with the result that they evinced fewer out of control behaviors and temper tantrums. Hence, the parents' positive changes had a positive ripple-effect throughout the entire family system.

In 1994 Bavin-Hoffman moved away from the quantitative research method and conducted a qualitative study that focused on married couple participants who in the past one to three years had attended professionally-lead 10-week filial therapy classes of the Landreth (1991) model (Bavin-Hoffman, Jennings, & Landreth, 1996). As many of the earlier quantitative studies had shown, the results indicated improved parent-to-parent as well as parent-to-child communication, increased unity between parents with regard to parenting tasks, especially in the area of setting and enforcing limits with children, improved family relations, particularly with regard to increased sense of parent-child closeness and interpersonal communications, and increased positive child behavior, including decreased aggression and increased self-control.

Continuing the move away from quantitative research studies, Lahti (1993) conducted an ethnographic study that also investigated the 10-week Landreth (1991) filial therapy model. Lahti's concern was to assay the results of filial therapy training on the parent, child, and child-parent relationships of the participants. Results indicated reduced parental stress levels as a result of the child-parent at-home play sessions, as well as increased parental self-confidence and awareness of their children's and their own personal needs. Also demonstrated were less need for parents to enforce limits (increased child self-control), increased communication and closeness between parents and children, reduced conflict between parents and children, and increased realistic expectations for their children. Further, increased parental perception of the

children's responsibility for their behavior and happiness, along with decreased parental perceptions of the children's aggression and withdrawn behavior were noted.

#### Filial Therapy with *At Risk* Families

The 1990s have been witness to a shift in focus of much of the research in filial therapy. The portability, manageability, and efficacy of Landreth's (1991) 10-week filial therapy model have been researched with a wide variety of populations including those with specialized clinical and *at risk* children and parents. Extensive research on the Landreth (1991) model has shown it to be equally helpful to this especially challenged population, in spite of the increased stress placed on parents and the increased likelihood of a negative impact on the children involved. Synopses of a selection of the more notable *at risk* research studies follows.

Five parents of chronically ill children were chosen for Glazer-Waldman's (1992) study. Group leaders, parents, and an independent observer all substantiated significant changes in children and parents, in both qualitative and quantitative formats. Especially noteworthy were the pre-filial therapy difficulties the parents experienced when attempting to separate their own anxiety from their child's level of anxiety. The parents' perception of their child's anxiety did not fit the child's reported level of anxiety. Pre testing revealed that the parents generally gave an over-inflated estimate of their child's degree of anxiety. It was as though they had no reliable benchmark from which to operate when judging their own or their child's anxiety level. The filial therapy training afforded the parents a reliable benchmark by which they were better able estimate the degree of their child's anxiety at a given point in time. Following the training, parent's estimates and children's reports of their anxiety levels were more closely aligned.

Glazer-Waldman's study also sought to normalize the parent-child interaction such that the relationship itself would not be clouded and dominated by the child's illness. Analysis of the

data offered support in this regard. The parents' reports suggested that they particularly enjoyed the positive aspects of the shared playtime with their children. It appeared that the special playtimes were able to shift the focus from the child's illness for both parents and children, resulting in more normalized interactions between them.

Bratton and Landreth's (1994) study demonstrated the effectiveness of the Landreth (1991) 10-week filial therapy model with single parents, a group whom research has shown to be among the most stressed of all parents. Pre and posttest videotape analysis of parental play sessions by outside raters demonstrated that experimental group parents realized significant increases on measures of demonstrated empathy, involved participation, and communication of acceptance with their children, as well as communicated permission for the child to be self-directing, as compared with the control group. Further, they indicated feeling empowered to parent more effectively, felt increased respect for their child's feelings and right to express feelings, the child's need for autonomy and independence, and the child's need to be recognized for their uniqueness. Also, the experimental group parents experienced increased unconditional love for their child and realized a notable decrease in their level of parental stress. The reported number of behavioral problems experienced by their child significantly decreased as well as compared to the control group.

Harris and Landreth (1995) investigated the effectiveness of a condensed version of the Landreth (1991) 10-week filial therapy model with incarcerated mothers. Two-hour training sessions were held bi-weekly for five weeks, with the mothers meeting between classes in special playtime sessions for 30 minutes twice a week with their visiting children. The experimental group mothers demonstrated significant increases in their empathic responses and acceptance of their children, as well as decreases in their perceived problem behaviors of the

children as compared to a control group.

Culturally diverse populations have also been the focus of filial therapy research studies. Native American parents living on the Flathead Reservation in Montana and Chinese parents living in Canada and Texas have participated in filial therapy research projects. Chau and Landreth (1997) investigated the use of the Landreth (1991) 10-week filial therapy with Chinese parents. Experimental group parents demonstrated significant increases in terms of their empathic responses and acceptance of their children, along with decreases in their perceived problem behaviors of the children versus control group parents. Of special interest was evidence that Chinese parents in the experimental group were able to permit the expression of negative feelings of anger and frustration by their children, a cultural taboo of centuries' duration among the Chinese. Experimental group parents also realized increases in demonstrated empathy and parental acceptance of their children, along with decreased levels of perceived stress related to parenting.

In 1996 Glover and Landreth evaluated Landreth's (1991) 10-week filial therapy model with Salish and Kootenai Native Americans living on their Montana reservation. Because of an unusually high degree of alcoholism among Native American parents, Native American children often experience significant emotional abuse and neglect. Glover's study showed that when compared to a control group, parents participating in the experimental group realized positive trends on measures of parental acceptance, improvements in children's self-concept, and reduction of parental stress. Glover noted that failure to achieve significance may have been because of cultural differences between the population investigated and the population norms for the testing instruments

Yuen and Landreth's (1997) study examined the efficacy of the Landreth (1991) 10-week

filial therapy model with Chinese parents who had immigrated to Canada. As was true with the experimental group parents in Chau's (1997) study with Chinese parents in Texas, Yeun found that experimental group parents significantly increased their ability to relate empathically with their children, while control group parents realized no change. Also, experimental group parents significantly increased their ability to accept their children as they were, perceived fewer problem behaviors with their children and less stress associated with being a parent. Equally significant was the finding that experimental group parents reported a significant increase in their child's self-concept.

Tew (1997) investigated the 10-week Landreth (1991) filial therapy model with chronically-ill children and their parents. As was true in Glazer-Waldman's study, parents in the experimental group demonstrated significant increases in parental acceptance, and reduced perceptions of children's anxious, depressed, and problem behaviors, as well as reduced stress related to parenting as compared to a control group.

Landreth and Lobaugh (1998) investigated the effects of the Landreth (1991) 10-week filial therapy model with incarcerated fathers and their children. Despite the harsh surroundings, posttest results revealed that the fathers who received filial therapy training had higher scores on unconditional love and parental acceptance and lower scores on parental stress scales than control group fathers. Also, they had higher scores on parental attachment and competence measures indicating that they had developed a degree of emotional closeness to their children that they had not experienced before. Further, experimental group fathers realized increases in their sense of power, virtue, competence, and significance as persons, demonstrating an overall increase in their sense of positive self-regard. Also noted were significant improvements in the children's self-concept.

Costas and Landreth (1998) evaluated the efficacy of the 10-week Landreth (1991) filial therapy model with non-offending parents of sexually abused children who had been identified as having been abused. In the experimental group significant changes were noted on several of the investigated measures. Among these were a reduction of parental stress, increased expression of empathy and communication of acceptance of children's feelings and behaviors noted during special playtimes, and increased parental unconditional love and parental acceptance. Costas and Landreth regarded as especially worth noting the experimental group parents' report of their children's behaviors as being within the normal range of scores after the training. In addition, parents in the experimental group were able to allow their child to lead and be more self-determining in the special playtimes, as compared to parents from the control group. Costas also regarded as remarkable this shift in the parents' need to control their child, in as much as it is common for non-offending parents to react to their child's sexual abuse by becoming overprotective, thus further interrupting the natural developmental flow in the child's life.

Smith (2000) investigated the effectiveness of the Landreth (1991) filial therapy model in intensive filial therapy training with child witnesses of domestic violence. Smith compared the modalities of intensive individual play therapy and intensive sibling group play therapy of child witnesses of domestic violence with data from the earlier studies of Kot (1995), and Tyndall-Lynd (1999). The Smith (2000) study condensed the time between parent training sessions to every-other-day, or daily sessions. The goal was to provide optimum benefit to the transient population of mothers and children at two domestic violence shelters in a major metropolitan area. Twelve filial therapy training sessions of 1 to 1 1/2 hours in length were attended by each of the mothers and each participated in 10 to 12 parent-child playtimes within a two to three week period. Results revealed that, even under the stress of the shelter setting, the mothers' ability to



convey empathy and acceptance to their children increased significantly. Also, children in the experimental group significantly increased in self-concept, and significantly reduced overall behavior problems. Results suggested that intensive filial therapy may be more effective than intensive individual play therapy and intensive sibling group play therapy with issues of emotional difficulties and related behavioral manifestations.

Robinson (2001) investigated the effectiveness of filial therapy training as a method to train fifth grade students to be therapeutic change agents for kindergarten children identified as having adjustment difficulties. Fifth grade students who received filial therapy training demonstrated significant increases in empathic responses, acceptance, and behavioral willingness to follow the kindergarten children's lead, and in involvement with the kindergarten children as compared to the control group.

#### Teachers as Therapeutic Agents of Change

Support for the use of filial therapy in training teachers to be therapeutic agents of change is found in studies by Guerney and Stover (1971), already mentioned, Harris, Wolf, and Baer (1964), Jones (1992), and Kranz (1972). L. Jones' study (2001) offers support for the role of high school students, trained in filial therapy, assuming the role of therapeutic agents with younger students. While varying in detail, these studies use as their touchstone the basic filial therapy model and demonstrate significance in changing some aspects of the relationship between teacher and child or older students and child.

Because teachers appear to play an increasingly significant role in children's lives in contemporary society (see earlier discussion), it is a logical next step to consider teachers as assuming more of an active role with school counselors, psychologists, and therapists in the community who are working with particular students from the teacher's class. The role of *co-*

*collaborator or co-therapeutic facilitator* with other professionals seems the minimum necessary if children are to receive the therapeutic assistance they need today and in the immediate future. However, this research study advocates for an even greater role for teachers of deaf and hard of hearing children, primarily because these teachers have more in-depth involvement over a longer period of time than do teachers in regular public or private school classrooms.

Commenting on the increased role of teachers with students and parents Myrick, as quoted in Draper, White, O'Shaughnessy, Flynt, and Jones (2001) offers:

Consultation with teachers and parents is based on the assumption that these people see their children or students more often than does a counselor. Improving teacher-student or parent-child relationships through consultation may have a more pervasive effect than counseling in a one-to-one relationship. Teachers and parents are in the best position to implement and support helping techniques and strategies (p. 5).

Pianta (1999) concluded that "...a caring relationship between an adult and a child serves to protect the child who may otherwise be at risk for learning and/or behavioral problems and ultimately school failure" (p. 5). Pianta (1999) regarded enhancing the teacher-child relationship as paramount to increasing competence levels and diminishing failure rates in public schools.

As noted earlier, Brown (2000) studied the effectiveness of an adaptation of filial therapy termed Child-Teacher Relationship training (CTR). Brown determined that classroom teachers in training typically were not given the opportunity to learn practical relationship building and communication skills with their students. Brown's study determined that Child-Teacher Relationship Training enabled positive change in the quality of the teacher trainee's relational interactions with children, parenting attitudes, attitude toward play therapy, and play therapy knowledge and skills.

### Kinder Therapy

White and colleagues (1997; 1999; 2000; 2001) have developed Kinder Therapy as an extrapolation of filial therapy for the purpose of training school counselors to in turn train classroom teachers to become therapeutic agents with their students. The Kinder Therapy model integrates B. Guerney's (1964, 1969) recommendation of the use of play therapy skills with the Individual Psychology of Alfred Adler (White, Flynt, & Draper, 1997; White, Flynt, & Jones, 1999; Draper, White, & O'Shaughnessy, Flynt, & Jones, 2001). The Kinder Therapy model offers the additional component of Individual Psychology to assist teachers "...in specific classroom strategies...that could help the teacher understand the child and interact with him or her more effectively on a day-to-day basis" (White, Flynt, & Jones, 1999, p. 366). Draper, White, O'Shaughnessy, Flynt, and Jones (2001) summarize the main purpose of Kinder Therapy as:

The main purpose of Kinder Training is to enhance teacher-child relationships, thereby improving the child's school adjustment both behaviorally and academically while simultaneously providing an opportunity for the teacher to improve relationship building skills and classroom management techniques with all students (p. 6).

In the Kinder Training model teachers endeavor to offer encouraging, self-esteem building statements to children as part of their classroom regimen of instruction (Draper et al. 2001). Thus Kinder Training combines play therapy with key aspects of Adlerian psychological theory (Adler, 1938; 1990) and teacher-counselor conjoint attempts at ameliorating a child's behavioral and emotional difficulties. The hope was that teachers would generalize to the classroom more effective learned ways of relating to their students that they practiced in the playroom (White et al., 1997; Draper et al., 2001).

In 1997, (White et al.) investigated the efficacy of the Kinder Therapy model in a large metropolitan school. The research design included teachers and their students of focus having a

thirty-minute play therapy session once a week for six weeks. Counselors offered consultation and feedback by observing videotapes of sessions, then debriefing the session with their assigned teachers. Emphasis was placed on strengthening the teacher-student relationship, understanding the child's behavior, and planning ways to generalize to the classroom the experience with the student in the playroom. Results of the initial Kinder Training research projects suggested tentative support for Kinder Therapy/Kinder Training as a preventative and remedial elaboration of filial therapy, using classroom teachers and school counselors to function as agents of change with their students.

### Summary

Deaf and hard of hearing children face developmental delays that make the acquisition and development of language and communication skills most difficult and challenging. Because they experience greater difficulty than their hearing peers in communicating their thoughts, needs, wants, and feelings, deaf and hard of hearing children are more likely to experience greater difficulty developing and maintaining a positive sense of self-regard. Also, they have a higher tendency to experience depression, estrangement, aggression, anger, frustration, and impulsivity. Therefore, the challenges for the teachers and parents of deaf and hard of hearing children are most difficult and can be at times intimidating.

Research into the nature and development of deafness and hearing impairment has been fraught with difficulty for the last century. Even agreeing to definitions of the terms deaf and hard of hearing has been impossible. While medical causes of deafness and hard of hearing are generally known, most causes of prelingual deafness are still unknown.

Prevalence figures for children who experience deafness are low when compared to other debilitating childhood illnesses, yet the high incidence of emotional and behavioral problems

among deaf and hard of hearing children and related challenges are complex and exceed the significance of prevalence figures alone. Because deaf and hard of hearing children experience a higher incidence of emotional and behavioral problems, they require a significant meaningful emotional relationship with their parents and teachers. Also, in order to meet the deaf child's unique needs for assistance with the acquisition of language, in addition to the child's parents, it seems logical and important that preschool and early childhood teachers learn to relate with their deaf and hard of hearing students using the child's innate and most natural form of communication, play.

Research indicates that parents who have been trained in basic child-centered, play therapy skills for use with their own children, by participating in filial therapy training, have been able to develop a more functional and emotionally nurturing relationship with their children, as well as feel empowered in their capacities to parent their children more effectively. In this sense, they have been trained to function as therapeutic agents of change with their children. Also, research supports the position that teachers are able to acquire play therapy relational skills for use with their students. Having participated in variations of the filial therapy model, teachers have realized more positive relationships with students, and have been able to help facilitate students' overall emotional growth as well.

In spite of these demonstrated needs of deaf and hard of hearing students, most programs for training teachers of deaf and hard of hearing children do not teach play therapy relational skills as part of their curriculum. Further, the extension of filial therapy to include the training of teachers of deaf and hard of hearing children has not been attempted. The aim of the proposed project was to evaluate the effectiveness of teaching filial therapy skills to preschool teachers of deaf and hard of hearing students to enable the teachers to become therapeutic agents of change

with their own students. To this end, a modified version of Landreth's (1991) filial therapy model was proposed as a viable training and preventive intervention with preschool teachers from a regional day school for the deaf and hard of hearing at a large center for communication disorders in Dallas, Texas.

## CHAPTER II

### METHODS AND PROCEDURES

This chapter presents the methods and procedures for data collected in this study. Sections included are: definition of terms, hypotheses, limitations of the study, the instruments administered for data collection, a discussion of the data collection, and treatment and an explanation of the data analysis procedures.

#### Definition of Terms

Aggression is the initiation of a hostile act against another person. It is often an expression of inner turmoil, anger, and frustration. Behaviorally, aggression is exhibited by the child's decision to attempt to destroy objects or to hurt another. For the purpose of this study, aggression was operationally defined as the score on the Aggression subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T, Achenbach, 2000).

Allowing the child self-direction is the behavioral willingness, as demonstrated by adult behavior, to follow the child's lead rather than attempting to control the child's behavior. For the purpose of this study, allowing the child self-direction was operationally defined as the teachers' scores on the Allowing Child Self-Direction Subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O'Connell, 1971).

Anxious-Compulsive is identified as feelings of apprehension, excessive fear, worry, and helplessness, accompanied by psychomotor restlessness and agitation, bodily tension, difficulty

concentrating, hypervigilance, and sleep disturbance, as well as an uncontrollable impulse to perform an act or behavior repeatedly. Anxious-compulsive is operationally defined as the student's scores on the Anxious-Compulsive Behavior Scale on the SEAI (Meadow-Orlans, 1983).

Anxious/Depressed is a psychological condition characterized by an hedonic mood, sadness, and feelings of loneliness, nervousness, guilt and fear. For the purpose of this study, anxious/depressed was operationally defined as the students' score on the Anxious/Depressed Subscale of the CBC/C-T (Achenbach, 2000).

Communication of acceptance as understood in this study refers to the adult's verbal expression of acceptance-rejection of the child. For the purpose of this study, communication of acceptance was operationally defined as the teachers' scores on the Communication of Acceptance Subscale of the MEACI (Stover et al., 1971).

Counselor of the deaf is a person who has completed training in and been certified by an approved program in the counseling of deaf and hard of hearing students for the school level in which they counsel children. A counselor of the deaf must also meet all certification requirements of the state in which they are certified.

Deaf education was defined as special education developed and intended for instructional purposes in the education of deaf and hard of hearing children. Deaf education is a part of a state regulated and sanctioned program that is designed to meet the particular educational needs of deaf and hard of hearing children.

Deafness was defined as the condition in which children have been medically

examined and determined to have a profound hearing loss (greater than 91 dB) and have been determined by an officially assigned early intervention program and an Annual Review and Dismissal (ARD) committee to meet Dallas Independent School District criteria for deafness.

Empathy refers to adults' sensitivity to children's current feelings and teachers' ability to verbally communicate this understanding to the child. For the purpose of this study, empathy was operationally defined as teachers' scores on the total Empathy Scale of the MEACI (Stover et al., 1971).

Intensive filial therapy training refers to tailoring the teaching of play therapy skills to classroom teachers for use with their students. For the purpose of this study, each teacher received 10 hours of in-school training, followed by weekly group supervision sessions, meeting for four two and a half hour, three, three and a half hour, or two five hour sessions. Each teacher also conducted 10 teacher-child play sessions within a 12 week time period, in addition to a pretest and posttest teacher-child play session.

Externalizing behavior problems refers to behaviors that are outward manifestations of inner conflict. These behaviors can include aggression, hyperactivity, and conduct problems. For the purpose of this study, externalizing behavior problems was operationally defined as the score on the Externalizing Behaviors Scale of the CBC/C-T (Achenbach, 2000).

Filial therapy was defined in this study as "a unique approach used by professionals trained in play therapy to train parents (teachers, in this study) to be therapeutic agents with their own children (students) through a format of didactic instruction, demonstration play sessions, required at-home (outside-the-classroom, in this study) laboratory play sessions, and supervision. Parents (teachers) are taught basic child-centered play therapy skills, including responsive listening, recognizing children's emotional needs, therapeutic limit-setting, building children's



self-esteem, and structuring required weekly play sessions with their own children/students using a special kit of selected toys. Parents (teachers) learn how to create a nonjudgmental, understanding and accepting environment that enhances the parent-child (teacher-student) relationship, thus facilitating personal growth and change for child and parent (teacher)” (G. Landreth, personal communication, June 27, 1995).

Hard of hearing was defined the same as the term Deafness, referring in this study to children who have been medically diagnosed with a profound hearing loss (greater than 95 dB) and have been determined by an early intervention program and Annual Review and Dismissal Committee to meet Dallas Independent School District criteria for deafness.

Hearing impaired was defined as a category of hearing loss severe enough to affect a child’s educational performance in a negative manner. Hearing loss describes the process in which some part of the outer, middle, or inner ear is not functioning in a normal manner, as diagnosed medically.

Impulsive, Dominating is characterized by the individual’s diminished ability or failure to resist acting on certain thoughts, internal drives, urges, or temptations, as well as behaving so as to attempt to create a sense of control or domination over the individual’s perceived sense of being out of control or helpless, with regard to certain thoughts, internal drives, urges, or temptations. For the purpose of this study, impulsive-dominating was operationally defined as the student’s score on the Impulsive, Dominating Behaviors scale of the SEAI (Meadow-Orlans, 1983).

Internalizing behavior problems refers to behaviors that are inward, representing a cluster of behavioral characteristics symptomatic of attempts to cope emotionally, resulting from inhibition to express feelings. Behavioral characteristics include withdrawal, anxiety, depression,

and suicidal ideation. For the purpose of this study, internalizing behavior problems was operationally defined as the students' scores on the Internalizing Behaviors Scale of the CBC/C-T (Achenbach, 2000).

Involvement was described in this study as an objective measurement of the adults' attention to and participation in the child's activities. For the purpose of this study, involvement is operationally defined as the teachers' scores on the Involvement Subscale of the MEACI (Stover et al., 1971).

Play therapy was defined as a "dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play" (Landreth, 1991, p. 14).

Profound hearing loss was defined as a medically diagnosed loss of hearing that has been determined to be greater than 91 dB. The hearing loss may have occurred pre or post lingually, or before or after birth.

Sociable, communicative behaviors are those behaviors on the Meadow-Kendall Social-Emotional Assessment Inventories for Deaf and Hearing-Impaired Students that compose Scale 1 of the inventory. For the purposes of this study, social, communicative behaviors were operationally defined as the students' scores on the Sociable, Communicative scale of the SEAI (Meadow-Orlans, 1983).

Teacher of deaf and hard of hearing students describes teachers who have completed accredited instruction and training in the teaching of deaf and hard of hearing students. They have been certified by the state in which they teach as Teachers of Deaf and Hard of Hearing

Students. For the purpose of this study, these were persons officially employed as teachers at the Preschool of the University of Texas at Dallas, Callier Center for Communication Disorders in Dallas, Texas.

Total communication was defined as the use of both oral and sign language instruction used in the education of deaf and hard of hearing children. For the purpose of this study, Total Communication referred to one method of classroom language instruction used in the preschool for deaf and hard of hearing students at the University of Texas at Dallas, Callier Center for Communication Disorders.

Withdrawn is defined as socially detached and unresponsive. For the purpose of this study, withdrawn is operationally defined as the students' scores on the Withdrawn Subscale of the CBC/C-T (Achenbach, 2000).

### Hypotheses

To carry out the purposes of this study, the following hypotheses were formulated:

1. The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Total Empathy subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

2. The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Communication of Acceptance subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

3. The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Allowing the Child Self-Direction

subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

4. The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Involvement subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

. 5. Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Total Behavior Problems subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

6. Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Internalizing Behavior subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

7. Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Externalizing Behavior subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

8. Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Anxious/Depressed subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

9. Students whose teacher receive filial therapy training will attain a significantly lower mean score on the Withdrawn subscale of the Child Behavior Checklist/Caregiver

Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

10. Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Aggressive Behavior subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

11. Students whose teachers receive filial therapy training will receive a higher mean score on the Sociable, Communicative Behaviors scale of the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) posttest than will students in the non-treatment comparison group.

12. Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Impulsive, Dominating Behaviors subscale on the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) posttest than will students in the non-treatment comparison group.

13. Students whose teachers received filial therapy training will attain a significantly lower mean score on the Anxious, Compulsive Behaviors subscale on the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) posttest than will students in the non-treatment comparison group.

### Limitations

This study had the following limitations:

1. Subject selection was limited to volunteer deaf education preschool teachers suggested for participation by the organizational leadership of an early childhood education program for deaf and hard-of-hearing students within a center for communication disorders in Dallas, Texas.

2. This study relied on a volunteer sampling of 24 of 27 early childhood classroom teachers and their students of focus from the preschool at the University of Texas at Dallas Callier Center for Communication Disorders. Due to the nature of the population and the purpose of this study, random selection was not possible.

3. Subjects included students who were in one of two classes at each grade level--either the class that uses only oral speech (*auditory communication*) or the class that uses oral speech *and* sign language (*total communication*). There was not an opportunity to compare the effectiveness of the experimental treatment with children in the *auditory communication* classes with children in the *total communication* classes.

4. There are very few testing instruments available with large sample size, adequate norms, validity, and reliability verification for use with deaf and hard-of-hearing preschool-age children.

5. The teachers in the experimental group who received the experimental training and supervision were coworkers with the teachers in the non-treatment comparison group. Though the experimental group teachers and the non-treatment comparison group teachers do not work side-by-side in the same classroom, they do work cooperatively and in conjunction with children outside the classroom setting. Their interactive working relationships as colleagues could have contaminated the comparative analysis. The control group teachers could have vicariously learned through observation some of the therapeutic skills utilized by the experimental group teachers. It is possible that they could have unintentionally implemented vicariously-learned play therapy skills with children in the non-treatment comparison group.

## Instruments

### Measurement of Empathy in Adult-Child Interaction

The Measurement of Empathy in Adult-Child Interaction (MEACI) is a rating scale adapted by Bratton (1994) from a scale developed by Stover et al. (1971) to operationally define empathy as related initially to parent-child interactions, subsequently utilized as a measurement of empathy in non-parent, adult-child interactions. This direct observational scale measures three specific adult behaviors: (a) communication of acceptance; (b) allowing the child self-direction; and (c) involvement with the child. These three behaviors are identified as major aspects of empathy in adult-child interactions and, when combined, provide a total empathy score. (NOTE: *Lower scores indicate higher levels of positive behavior on the subscales and total scores*).

The Communication of Acceptance subscale measures the parents'/adults' verbal expression of acceptance-rejection of the child's feelings and behavior during spontaneous play sessions. The dimension of acceptance is viewed as a necessary condition for optimal development in the child's self-worth and the major element in the communication of empathy (Stover et al., 1971).

The Allowing the Child Self-Direction subscale measures the verbal expression of acceptance and the behavioral willingness on the part of the parent/adult to follow the child's lead rather than attempt to control the child's behavior (Stover et al., 1971).

The Involvement subscale measures the parents'/adults' attention to and participation in the child's activity. Stover et al. (1971) found that parents who exhibited high level of acceptance and allowed the child self-direction, also demonstrated high levels of involvement.

The Measurement of Empathy in Adult-Child Interaction (MEACI) is a 5-point bipolar scale used to rate the three dimensions of parental/adult behavior every three minutes for six consecutive coding intervals. The scale ranges from a high rating of 1 to a low rating of 4. Each point on the scale is followed by typical responses obtained from codings of the direct observations of parent-child, adult-child interactions. Considering the three subscales together as components of empathic behavior, the highest level of empathy are evident when the parent/adult is commenting frequently on the child's expression of feeling or behavior in a genuinely accepting manner; is clearly demonstrating that the child is fully permitted to engage in self-directed activity, and is attentive to the child's behavior. The lowest level of empathic communication is one in which the parent/adult is verbally critical and rejecting of the feelings or behaviors of the child; cajoles, demands, and continually redirects the child's activity; and is self-involved, preoccupied, or shut off from the child.

Reliability coefficients were established for each of the three subscales. After four training sessions for collaborative rating on a half-hour play session, followed by discussions, six pairs of coders independently rated 7 to 10 parent-child play sessions of 20 minutes each.

The average reliability correlation coefficient for the Communication of Acceptance scale was .92. The Allowing the Child Self-Direction subscale had a median correlation of .89, and the Parental Involvement subscale had an average coefficient of .89 (Stover et al., 1971).

Construct validity for each subscale and the total empathy score was demonstrated in a study group with 51 mothers who participated in filial therapy training (Guerney & Stover, 1971). The filial therapy training method was utilized to demonstrate the validity of the scales because this method involved training parents in empathic skills closely related to the behaviors the scales intended to measure. The parents' levels of empathic interactions with their children



were measured three times: (a) a pre-training play session; (b) a first post-training play session; and (c) a third post-training play session. Highly significant increases, at the .0005 level, between the pre-training and first post-training play session were obtained on each subscale and for the total empathy score. A significant increase, at the .01 level, between the first and third post-training sessions demonstrated that the scales are extremely sensitive measures of empathic behaviors. Concurrent validity established by a .85 correlation at the .005 level between the Measure of Empathy in Adult-Child Interaction (MEACI and previously developed empathy measure for adult-children interaction (Guerney, Stover, & DeMeritt, 1968).

#### Child Behavior Checklist/Caregiver-Teacher Report Form

The Child Behavior Checklist/Caregiver-Teacher Report form (CBC/C-T) is the newest version of a well-established and recognized instrument for the identification of behavioral and emotional difficulties in children ages eighteen months (in the newest version) to 18 years. It consists of 120 items, requiring a fifth-grade reading level, and takes approximately 20 minutes to complete. It is categorized as a self-administered test, rating the existence of behavioral symptoms on a scale of 0 to 2--0 indicating the behavior is not true for the child, and 2 indicating that the child often demonstrates that behavior. This checklist was designed to record, in a standardized format, behavioral symptoms and competencies of children as perceived by their parents or surrogates.

Originally developed in 1986 by Achenbach and Edelbrock, the revised version of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T, Achenbach, 2000) was used in this study. Specifically, this study focused primarily upon the Internalizing and Externalizing domains of the Child Behavior Checklist (CBC/C-T) behavior scales. The teachers

were relied upon to complete the checklist because the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) requires the perception and judgment of a child's behavior.

Internal consistency for the (CBC/C-T) was demonstrated by Cronbach's alpha. For girls between the ages of 4 and 11, Cronbach's alpha is .90 for Internalizing behavior problems, and .93 for External behavior problems. For boys between the ages of 4 and 11, Cronbach's alpha is .89 for Internalizing behavior problems, and .93 for Externalizing behavior problems. Inter-interviewer reliability of item scores was established at .959. Intraclass correlations from three matched samples of children showed a high level of reliability between raters, indicating that scores obtained for each item are relative to scores from each other item.

Test-retest reliability was established at .89 for Internalizing behavior problems, and .93 for Externalizing behavior problems. Scaled scores were evaluated after two years to establish long-term stability, which was calculated to be .70 for Internalizing behaviors, and .93 for Externalizing behaviors. Scores were discovered to lower over time among children receiving mental health treatment, indicating the scale remains sensitive to minor changes as a result of intervention. Content validity of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) is also established. All 120 items were associated with clinical status at the .01 level of significance. Criterion-related validity was supported by the ability to effectively distinguish between referred and non-referred children.

#### Meadow-Kendall Social-Emotional Assessment Inventories for Deaf and Hearing Impaired Students (SEAI)

The Meadow-Kendall Social-Emotional Assessment Inventories for Deaf and Hearing Impaired Students (SEAI), constructed by Meadow-Orlans and developed in collaboration with Getson, Lee, and Stamper, all of the Center for Studies in Education and Human Development,

Gallaudet University (1983) was designed to be completed by teachers and other educational personnel in close contact with deaf students. The preschool inventory, which was used in this study, contains 49 items divided into four scales (Sociable, Communicative Behaviors; Impulsive, Dominating Behaviors; Developmental Lags; and Anxious, Compulsive Behaviors) plus three special items related to deafness. Norms are provided for girls and for boys according to three age groups: 36 to 47 months, 48 to 59 months, and 60 to 83 months.

The SEAI utilizes classroom teachers based on the assumption that teachers “have the greatest opportunity to observe students’ behaviors over time and in a variety of situations”...therefore, including classroom teacher “assessments should be both valid and reliable, assuming that they are asked to assess relevant dimensions of behavior”...“as demonstrated by a number of research studies” (Bower, 1958; Maes, 1966 as cited in Meadow-Orlans, 1983). The inventories include items describing actual behaviors, so that few inferences about children’s motivations are necessary.

Normative data was collected on approximately 800 children enrolled in special programs for hearing impaired children, between the ages of 3 years, 0 months through 6 years, 11 months old, from a geographically representative group of programs from 10 states from various regions of the United States. The total number of participating programs was 54. Of the 857 students within the normative population, 62 percent were white, 20 percent black, and 14 percent Hispanic. Twenty-one percent were enrolled in oral-only educational programs and 78 percent in total communication programs. Sixty percent were deaf at birth. Almost half were classified as having profound hearing loss. Three-quarters had no deaf relatives.

Individual items were grouped into Scales 1, 2, 3, 4 and Special Deaf Related Items by means of factor analysis. Scale 1 (Sociable, Communicative Behaviors), consisting of 18 items

that describe sociable, communicative behaviors, received an inter-item reliability score of .92, utilizing Cronbach's alpha. Scale 2 (Impulsive, Dominating Behaviors), consisting of 16 items describing primarily impulsive, dominating behaviors, received an inter-item reliability of .91 utilizing Cronbach's alpha. (Note: A high score on this scale reflects the absence of those negative kinds of behaviors.) Scale 3 (Developmental Lags/Tasks), which contains six items that reflect the achievement of developmental or maturational tasks (such as toilet training) received an inter-item reliability of .80. Scale 4 (Anxious, Compulsive Behaviors), which contains six items related to anxious, compulsive, or obsessive kinds of behaviors, received an inter-item reliability of .75. (Note: A high score reflects the absence of the negative behaviors). The three special items related to deafness describe the child's response to amplification equipment and to speech and auditory activities.

To establish preschool norms, mean scale scores were computed for each child for whom inventories had been collected. A series of two-way analyses of variance was performed. In order to reflect significant developmental, age and sex differences, norms were created for boys, girls and three age levels (36 to 47 months; 48 to 59 months; 60 to 83 months) for Scales 1, 2, 3 and 4. Special items related to deafness were presented in terms of mean scores for the total group without regard to either age or sex.

Test-retest reliability generally refers to the extent of agreement in ratings or scores on the same instrument completed at two different times for the same subject, by the same rater/administrator. The test-retest reliability scores (measured by Pearson  $r$ ) derived from combining the correlation coefficients from four programs (involving 159 children), were as follows: Scale 1 - .87; Scale 2 - .77; Scale 3 - .90; Scale 4 - .70; Special Items - .75.

Inter-rater reliability was established in the Central North Carolina School for the Deaf with the ratings of 21 children. Teachers and teachers' aides simultaneously observed and rated children, producing the following inter-rater reliability scores: Scale 1 - .95; Scale 2 - .88; Scale 3 - .84; Scale 4 - .75; Special Items - .84.

Substantiating validity was difficult because the reason for developing this new inventory was the lack of other instruments for use with deaf children. Because of the unavailability of other instruments that were researched and normed for the clinical assessment of deaf children, validity was assessed through an analysis of the relationship between the five scores from the SEAI inventory and a global assessment questionnaire completed by teachers at the time the inventory was collected. The "general assessment" questions that teachers were asked to answer (on a four-point scale) were as follows:

1. Adjustment: "Do you consider this child to be generally well-adjusted?"
2. Maturity: "Do you consider this child generally mature for the age level?"
3. Self-regard: "Do you consider this child to have a high level of self-regard?"

4. The correlations between the teachers' general assessments of the children and the scores on the Preschool Inventory of the SEAI are summarized in Table 1.

Table 1

*Correlations between Teachers' General Assessments of Children and Scores on the Preschool Inventory*

	Scale				
General Assessment	1	2	3	4	Special Items
Adjustment	-.69 (812)	-.58 (810)	-.44 (815)	-.42 (800)	-.36 (789)
Maturity	-.62 (812)	-.56 (810)	-.53 (815)	-.34 (800)	-.31 (789)

Self-Regard	-.70 (807)	-.50 (804)	-.48 (809)	-.37 (795)	-.34 (784)
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The Social-Emotional Assessment Inventory (SEAI) should be seen as one tool that can be used to flag students who need extra attention in particular areas...It can be helpful in implementing an individualized program so that social and emotional areas are emphasized in the curriculum for the child who needs them...[and is not to be used as a static view of behavior that may be tied to differential rates of development or maturity” (Meadow-Orlans, 1983, p. 34).

#### Selection of Subjects: Description of the Preschool at the Callier Center for Communication

##### Disorders

For this study, volunteer subjects, comprised of teachers and preschool students, were recruited from The University of Texas at Dallas Child Development Preschool at the Callier Center for Communication Disorders. The Callier Center for Communication Disorders contains a highly respected preschool for deaf and hard of hearing children. Designated by the Texas Education Agency Division of Services for the deaf, the Callier Child Development Preschool functions as a Regional Day School for the Deaf, while the Callier Center for Communication Disorders serves individuals of all ages who have a wide range of communication disorders.

The Callier Child Development Preschool serves deaf and hard of hearing children from ages two to six, as well as hearing children of the same age. Deaf and hard of hearing students are integrated into a regular preschool setting while receiving special deaf education services. Classes are formed based on the child’s age on September 1 of a given year.

Each new two to three year old child is assigned to a three or four-member teaching team that will remain with that child and the child’s class for three years, barring teacher or paraprofessional changes. Therefore, the same group of children, for the most part, and the same

team of teachers graduate together from the two-three year old class to the three-four year old class and, finally, to the four-five year old class. This allows the children to have a continuity of teachers who work with them for a three-year block of time during the crucial preschool years.

As children enter kindergarten, they receive a new team of teachers. Therefore, the kindergarten teaching team (only two teachers, not three or four, per class) receives a new group of students each year. In addition, communication specialists plan and work collaboratively with each teaching team to provide full support for each deaf and hard of hearing student in the areas of language, hearing/listening, and speech development. Counseling (by a deaf education certified child counselor), health management, and occupational therapy are included in the students' individual educational programs as required.

At the Callier preschool, there are two classrooms at each age level (two, two to three-year-old classes, two, three to four-year-old classes, two, four to five year-old classes, and two, five to six-year-old classes), eight classes total, with the possibility of 27 teachers if all chose to participate in the study. Of the 27 potential teachers, 24 volunteered to participate in the study.

The decision as to whether a deaf or hard of hearing student will attend an *auditory communication class* (oral speech only is used; no sign language) or *total communication class* (sign language plus oral speech are utilized) is determined by an Admission, Review, and Dismissal committee of the Dallas Independent School District, in consultation with the child's parents before school begins.

As noted, children who have no hearing difficulty also attend preschool at the Callier center. These students are assigned to either *auditory* or *total communication* classes on a first-come, first-served basis, determined by parental preference. Late-enrolling students are assigned based on class or school needs at the time.

Hence, at each grade level, one class uses *only oral speech (auditory communication)*, and the other *sign language and oral speech (total communication)* with students. Since each class combines both deaf and hard of hearing students and normal-hearing students, ideally, for this study the experimental group would be composed of two *auditory communication* classes and two *total communication* classes, in order not to skew the research should there be differences due the inclusion/exclusion of sign language in the education/communication process. However, a complete balance between *auditory* and *total communication* classes was not possible in this study. Therefore, in order to provide a comparable range of ages of children participating in the study, the experimental group included teachers of one two-three year old *auditory communication* class with three teachers, and three *total communication* classes: one three-four year old class with four teachers; one four-five year old class with three teachers; and one kindergarten class with two teachers. The reverse composition defined the control group: one *total communication* class of two and three year olds with three teachers; and three *auditory communication* classes. The *auditory communication* classes in the experimental group were composed of the other class of three and four year-olds, four and five year-olds, and kindergarten classes, including four teachers, three teachers and two teachers, respectively.

Preschool classes at the Callier center are generally taught by a team of three or four teachers: a certified deaf education teacher; a deaf education paraprofessional/ assistant; a certified early childhood teacher; and a child development associate/ assistant. The certified early childhood teacher usually functions as the case manager for the hearing students in the class, while the certified deaf education teacher usually functions as the case manager for the deaf/hard of hearing students in the class. Typical class sizes and the teacher-student ratio vary



according to the age range of the students in classes. The enrollment during the semester of this study was as follows:

Two, Two and Three Year Old Classes:

*Auditory Communication:* 11 hearing students; 4 deaf/hard of hearing students; 3 teachers in the teaching team as described above.

*Total Communication:* 11 hearing students; 5 deaf/hard of hearing students; 4 teachers in the teaching team as described above. One teacher did not participate in the project.

Two, Three and Four Year Old Classes:

*Auditory Communication:* 14 hearing students; 5 deaf/hard of hearing students; 4 teachers in the teaching team as described above.

*Total Communication:* 14 hearing students; 17 deaf/hard of hearing students; 4 teachers in the teaching team as described above.

Two, Four and Five Year Old Classes:

*Auditory Communication:* 14 hearing students; 5 deaf/hard of hearing students; 4 teachers in the teaching team as described above. One teacher did not participate in the study.

*Total Communication:* 14 hearing students; 10 deaf/hard of hearing students; 4 teachers in the teaching team as described above. One teacher did not participate in the study.

Two, Five and Six Year Old Classes:

*Auditory Communication:* 8 hearing students; 3 deaf/hard of hearing students; 2 teachers, 1 teacher dual certified as a deaf educator and an early childhood educator, 1 deaf education paraprofessional.

*Total Communication:* 10 hearing students; 6 deaf/hard of hearing students; 2 teachers, both dual-certified as deaf and early childhood educators.

The ratio of deaf education enrollment at the Callier Preschool is flexible and determined by the number of deaf or hard-of-hearing children identified and placed through the Admission, Review, and Dismissal (ARD) committee of the Dallas Independent School District, as required

of public educators by the State of Texas. The percentage of deaf and hard-of-hearing children with hearing students, though differing at times, is generally 30 to 40 percent deaf and hard-of-hearing, occasionally reaching a 50/50 ratio of deaf and hard-of-hearing students with hearing students. The 5-6 year old classrooms usually have a higher percentage of deaf/hard-of-hearing students in comparison to hearing students than is found in the classrooms with younger children.

The hearing children are referred to as regular preschool students; these students' tuition is private pay. Many hearing students are children of employees and faculty of the University of Texas Health Science Center and Southwestern Medical School that is located adjacent to the preschool. All of the deaf and hard-of-hearing students are enrolled through the Dallas Independent School District, the city's public school district.

#### Selection of Teachers: Enrollment of Volunteer Participants--Teachers and Students of Focus

The Callier Center's Preschool Director of Education and Associate Director of Education agreed to allow all preschool and kindergarten teachers to be invited to participate in the study on a voluntary basis. The term *teachers* in this study is a collective term that refers to any and all of the aforementioned professionals and paraprofessionals who teach preschool and kindergarten children at the Callier Preschool.

At an initial in-service training meeting, the researcher presented the purpose and structure of the study to all teachers of the preschool and kindergarten classes at the beginning of the fall term. The researcher explained the potential benefits of the training based on prior research findings, the time frame of the study, and the involvement requirements of volunteer participants. Assignment to the experimental group and the control group was explained with the

added assurance that teachers assigned to the control group would receive the opportunity for comparable training to those in the experimental group following the completion of the study.

At the recruitment meeting, all teachers were given a brief oral description of the study that included participation requirements for involvement. Potential subjects were informed that there was no charge for the training and that the Directors of Education of the preschool had pre-approved their participation. Further, the presentation of the program and the included information flyer indicated that the University of North Texas Institutional Review Board had approved the study as designed prior to its beginning. Also, the Director and Associate Directors of Education of the preschool agreed that there would be no reprisal for those choosing not to participate and, as an added incentive, indicated that the training would be in lieu of other required in-service and continuing education programs, with appropriate continuing education credits given for participation in the research project.

In addition, at the initial recruitment meeting, interested teachers were given information sheets that described the study, including potential positive benefits to their students, themselves, and the other students in their classrooms (Appendix A). Parental consent forms (Appendix C) were furnished to teachers to give to interested parents of potential students of focus. Finally, the researcher showed a videotape that he had developed, which featured parents who had learned the basic filial therapy skills for use with their own children. The videotaped parents described how learning the filial therapy skills had improved the quality of their overall emotional relationship with their own child (or children), including the specific skills they had learned. Among the skills the parents enumerated were reflective listening, setting limits, and empathic appreciation for their particular child's world based on their observation of the child's play in specifically prescribed at-home play sessions. After showing the videotape, fourteen teachers

signed the list to participate in the study. By the end of the following week, ten additional teachers had volunteered to participate. Thus a total of 24 teachers, from a possible total of 27, elected to participate in the research project.

Teachers were selected to participate in the study based on the following criteria of eligibility: (a) must be an early childhood, deaf education, or paraprofessional teacher in the Callier preschool, actively assigned to either a two and three year old class, a three and four year old class, a four and five year old class, or a five and six year old/kindergarten class; (b) were willing to select (after receiving written parental permission) from his or her own classroom, at least one of his/her students as a *student of focus*, with the student being between the ages of 2.0 to 6 years, 11 months; (c) were able to speak, read, and write the English language, and, if teaching in a class using *sign language* and *oral speech (total communication)*, were proficient in sign language; (d) agreed to complete 20-22 hours of filial therapy training led by the researcher within the designated time frame designated for the study; (f) were willing to attend pre and post testing videotape sessions, complete two written testing instruments for pre and posttesting purposes, and conduct videotaped teacher-student play sessions at intervals between instructional sessions; (g) were willing to participate in 10 teacher-student play sessions, averaging 30 minutes in length, once a week, and commit to videotape a minimum of 3-4 sessions for review in the teacher instructional class; and (h) were willing to sign the teacher consent form.

Each student selected to participate in the study was chosen based on the following eligibility criteria: (a) must be a child diagnosed as deaf or hard-of-hearing by the DISD/ARD intake process; (b) must be a classroom student of a participating teacher; (c) must be within the age range of 2.0 to 6.11 years; (d) must be able to communicate either through sign language or

verbally at a minimal level determined by the student's teacher or the Director and/or Associate Director of Education; (e) must be given parental permission to participate by means of a signed parent permission form; (f) must be able to attend pre and post testing videotaped teacher-student play sessions; and (g), must be able to participate in 10 teacher-student play sessions, averaging 30 minutes in length.

The researcher met with each teacher participant who met the specified criteria, either in small groups or individually, to: (a) clarify in further detail the purpose and the requirements of the filial therapy training; (b) provide information about how confidentiality would be maintained throughout the project; and (c) answer any questions the participants had before they signed the consent form and were assigned to either the experimental or non-treatment comparison group.

After the teachers agreed to participate in the project, teachers were assigned either to the experimental group or non-treatment comparison group. Each teacher then selected a *student of focus* from the deaf and hard-of-hearing students in his/her class room. Thus, a total of 24 students were selected. Each *student of focus* selected by teachers in the non-treatment comparison group was used only for pre and posttesting purposes. The students of focus chosen by the experimental group teachers were pre and posttested, and their teachers also received the experimental treatment, in this case the filial therapy skills training. Also, the experimental group students were videotaped at intervals as their teachers were receiving the filial therapy skills training. These between-instructional session videotapes served as the basis for in-class supervision of the teachers' work with their students of focus.

In order to not contaminate the research by having a control group teacher co-teaching with an experimental group teacher, it was necessary to assign teams of teachers collectively.

There was sufficient teacher participation at each grade level and within each of the eight classes, so that one class of each grade level was in the experimental group and one class of the same grade level was in the non-treatment comparison group.

The experimental group of teachers was composed of 10 females and 2 males, of whom 58% were Caucasian, 8% were Hispanic, and 33% were African American. Of the two males, 1 was Hispanic and 1 was African American. The non-treatment comparison group of teachers was also composed of 10 females and 2 males, of whom 80% were Caucasian, 10 % were Hispanic, and 10% were African American. Of the males, both were Caucasian.

The experimental group of students of focus chosen by the teachers was composed of 6 males and 6 females, of whom 25 % were Caucasian, 42% were Hispanic, and 33% were African American. The mean age of the students of focus in the experimental group was 49.7 months. The non-treatment comparison group of students of focus chosen by the teachers was composed of 7 males and 5 females, of whom 42% were Caucasian 42% were Hispanic, and 16 % percent were African American. The mean age of the students of focus in the non-treatment comparison group was 48.7 months.

During the training, each student of focus received one play session per week for 10 weeks, with the teacher from the experimental group acting as facilitator of the therapeutic experience. Because of unavoidable scheduling conflicts, the experimental group play sessions and all posttest videotaping sessions were held in a different room from the one used for the pretest videotaping sessions. This room was less than ideal for the purposes of the experiment. Additional comments concerning this room are offered in the Collection of Data section.

Before the experimental treatment began, an interview of preschool personnel, comparison of intake profiles, review of each classroom, and a comparison of classes using *oral*

*language only* and classes using *sign language* plus *oral language* concluded that the classes in this study were similar in teacher competency, classroom dynamics and the children served.

### Collection of Data

A pre-test, post-test, non-equivalent control group design was used to carry out the objectives of this study. The non-equivalent control group of students was referred to as the non-treatment comparison group. Pretesting sessions for the experimental group and the non-treatment comparison group were held at the school during the school day, prior to the beginning of training for the experimental group of teachers. Teachers of the three and four year old classes and the four and five year old classes served last year as the teachers of their returning students. Because of the pre-existing teacher-student relationship, these teachers and their *student of focus* were pretested during the first week of the project. The teachers of the two and three year old classes and the five and six year old/kindergarten classes had a new group of students who had not previously been in their classroom. In order to give an additional week to observe and experience students, teachers of these classes were pre-tested the third and fourth weeks of school. Training began the fifth week of school.

The pretesting included the teachers' completion (on their own time) of the Child Behavior Check List/Caregiver-Teacher Report Form (CBC/C-T), the Meadow-Kendall Social Emotional Assessment Inventory for Deaf and Hearing-Impaired Students (SEAI), demographic information on each *student of focus* and the returning of the teacher and parent consent forms. In addition, the pre-testing included videotaping a 20-minute teacher-child play session (for the MEACI) with each teacher and his or her *student of focus* in a designated play area, using toys and materials recommended by Landreth (1991).

The room used for video pretesting was a visiting teacher's classroom that the researcher set up as a playroom. The room itself was spacious with an abundance of room for teacher and student to have their playtime. The entrance to the room was also the entrance to an audio testing room that was in use some of the time during the pretest periods. However, the coming and going of the audiologist and her students did not appear to affect negatively the initial play experience of the experimental and comparison group teachers and their students of focus. Also, outside the room used for pretest videotaping was a large, open common area used by four preschool classes. This room contained computer stations, classroom pets in cages, a sound system for musical use with the children, and served as their common gathering area for recess, lunch, field trips, and all larger meetings of the four classes. During the pretest videotaping sessions, at times the noise in the outer room was quite loud. However, it appeared not to be disruptive to the teacher or student who were being videotaped at the time.

At the outset of the pretest videotaping session, each teacher was given the same introductory explanation as to how the time could be used. This information, in turn, was communicated by the teacher to the child in the mode of language used in the child's classroom (*oral language only* or *sign language plus oral language*). Both teacher and student were told that they had 20 minutes to play with the playroom toys in most of the ways they would like. In addition, the researcher indicated which areas of the room were off-limits during the videotaping session (e.g. the visiting teacher's desk and the items on it were not to be used during the play session). The researcher then began recording the play session and left the room. The researcher returned to the room and informed the teacher when they had 3 minutes remaining in their play time session. At the end of the designated time, the researcher reentered the room announcing that the playtime was over, while turning off the video camera. At this time, the student and



teacher returned to their normally-scheduled activities. Since teachers and students were not told to pick up the toys or leave them before returning to their regular classroom, the decision was left to the teachers. Virtually all teachers picked up the toys, enlisting the student's help also. The researcher took this to be a carryover from their self-picture as classroom teachers: preschool teachers spend much time daily picking up from one activity before going to the next.

The pretest videotaping required a full three days, Monday through Wednesday, to complete. The illness of one student of focus delayed the taping of this student and her teacher for one week. However, all pretest videotaping was complete before the experimental group training began the day after pretest videotaping was complete.

The working support of the Associate Director of Education was essential throughout the research project, but was especially necessary during the pre and posttest videotaping when 24 teachers and their students of focus had to be scheduled and coordinated to meet ongoing teaching requirements. Remarkably, the dropout rate for this project was nil, with the same 24 teachers and students of focus being pre and posttested on all measures. This is an unmistakable indication of the teachers' commitment and interest in the project and their willingness to follow through on their commitment. The only change throughout the project was the decision of one teacher in the experimental group who decided to choose a different student of focus after consultation with the researcher. It was decided that the student selected as the teacher's initial choice of student of focus likely had a number of additional undiagnosed emotional and possibly neurological conditions that would reduce the likelihood of the student's being able to utilize the play opportunity offered by the research project as it was proposed (10 weeks of training). This particular three year-old child appeared so developmentally delayed because of her multiple difficulties, including profound deafness, that another child might be better suited to the

proposed time limitations of the project and the teacher may better learn the filial therapy skills with a child who was somewhat more responsive. Despite the usual teacher and student difficulties that occurred during the project (such as absence from school due to illness, for example), the experimental group of teachers was able to stay on track with the class schedule or make up what they had missed in class and with their students of focus.

The posttest sessions were conducted immediately following the 10 weeks of filial class instruction before the Christmas holiday break. The video posttests followed the same protocol as the pretest sessions. Each teacher and student in both the experimental and non-treatment comparison groups were videotaped for 20 minutes in the designated play area using the same toys as were used in pretesting. Also, each teacher again completed the two written instruments on his or her student of focus, the CBC/C-T and the SEAI. However, one change from the pretest experience was unavoidable. As noted earlier, the posttest videotape sessions were held in a room different from the room in which the video pretesting was done. Because of scheduling conflicts and space demands, it was impossible for the experimental group teachers to hold their practice play sessions in the visiting teacher's room. A much smaller, less preferable room was used for the actual teacher-student practice filial sessions. Further, the video posttesting for both the experimental and non-treatment comparison group was done in this same room. Long and narrow, containing a teacher's desk and file cabinet, a computer dolly on wheels, and a number of stored boxes, this room was made as workable as possible for the research project purposes. It was the best space available for use at the time, and it appeared to approximate the difficult circumstances under which many play therapy programs in schools and other institutions have begun. In this regard, and on reflection, the space seemed favorable for an *ab initio*, untried filial therapy training program such as this to be conducted.

## Treatment

The training of the experimental group of teachers and their students of focus basically followed the Landreth (1991) 10-week filial therapy model. The primary foci of the classes were several: 1) helping the teachers to better understand their student of focus and the student's play behavior during the practice play times (rather than focus on the student's specific difficulties); 2) building their relational skills and enhancing the teacher-student relationship; 3) preparing the teachers to respond with empathic understanding and acceptance of their student of focus; and 4) allowing the student to be self-directive and self-responsible.

## Modification of the Filial Therapy Model for Use with Teachers of Deaf and Hard of Hearing Preschool Children

The experimental group of teachers met for once each week for 10 weeks and received a total of 25 hours of classroom instruction that included regular supervision and discussion of their videotaped sessions with their students of focus. The in-class instruction also included modifications deemed necessary to meet the special needs of these teachers and their students of focus. For example, rather than follow the traditional schedule of 10 weekly, two-hour training sessions, the schedule was modified to fit the teachers' existing school and personal schedules, to minimize the time teachers were required to be out of the classroom, and to limit the amount of time participating teachers were required to attend training sessions outside of the workday. Because several of the teachers worked different daily time schedules at the preschool than their experimental group peers, the following dates and time schedule was used for filial training:

Session #1	Thursday, October 4	3-6pm
		6-9pm, Repeat of 3-6pm session
Session #2	Monday, October 8	1:30-3:30pm

Session #3	Tuesday, October 16	3-6pm
		6-9pm, Repeat of 3-6pm session
Session #4	Monday, October 22	1:30-3:30pm
Session #5	Monday, October 29	1:30-3:30pm
Session #6	Tuesday, November 6	3-6pm
		6-9pm, Repeat of 3-6pm session
Session #7	Monday, November 12	1:30-3:30pm
Session #8	Monday, November 19	1:30-3:30pm
Session #9	Tuesday, November 27	3-6pm
		6-9pm ,Repeat of 3-6pm session
Session #10	Tuesday, December 4	3-6pm
		6-9pm, Repeat of 3-6pm session

When teacher absences occurred, the researcher met before or after regularly scheduled sessions to keep all teachers current with each other. To insure that all teachers were taught the same material, each was furnished a notebook during the first class meeting. The notebooks contained the handouts for each class session. The handouts highlighted each day's skill or concept and included a visual graphic or cartoon to reinforce the learning (Appendix E). Each notebook was organized sequentially by session and all handouts were in the same order. Also included was paper for note taking during each class session. During the first three class sessions, demonstration videotapes were shown, with care taken to show the same tapes to all group members, regardless of their time of meeting. After teachers began meeting with their students of focus in the playroom, videotapes of their sessions most often became the focus of illustration for the filial concepts taught that session. The goal was to personalize instruction and

aid in the teaching of all teachers in the group. Use of videotapes of their own student play sessions seemed essential to maintaining the teachers' interest and commitment to improvement. They also served to mobilize the teachers' emotional support for their colleagues as they each worked to master the filial skills being taught.

Most often, all group members attended the Monday 1:30 to 3:30 pm class meetings, since this time was already designated as a weekly training period in each of their schedules. The one Thursday and four Tuesday meetings met in two sections, a 3 to 6 pm and 6 to 9 pm section. Usually, eight of the experimental group teachers attended the 3 to 6 pm session and four members attended the 6-10 pm session. Differing class time requirements on these days necessitated the two class sessions on the same day. A total of 25 classroom instructional hours in filial therapy was furnished during the 10 meeting times for all group members.

As in filial training with parents, the training combined didactic instruction, role play, and other forms of experiential learning, such as videotapes chosen to illustrate the didactic material, along with emotional support and empathic understanding. With the exception of one videotape of a non-speaking autistic child, the instructional videotapes presented by the researcher demonstrated play therapy with hearing children. Hands-on learning experiences were essential to the instruction (e.g., role plays during which the teachers took first the part of the student, then the teacher, while the researcher responded with emotional support and suggestions of alternative responses to the teacher-student's play behaviors in the role play. Following the first two class instructional sessions, during which the teachers received five hours of training, the teachers had their first playtimes in the playroom with their students of focus. The researcher proposed to videotape every other play session the teachers had with their students so that these

tapes could be used for in-class discussion with the researcher and the other class members. However, given the opportunity, several teachers chose to videotape each of their sessions.

Throughout the course of training, the researcher and experimental group teachers worked together to develop workable strategies to bridge the developmental communication and language gaps present with deaf and hard of hearing children. This creative conjoint consultative process was critical to the overall training of the teachers and any success they may have had in implementing the basic filial therapy skills with their students in the playroom.

The process grew necessarily out of the researcher's presentation of the fundamental filial therapy concepts and strategies for enriching the parent/child, teacher/child relationship and the teachers' experience in working with deaf and hard of hearing children. The researcher was guided by the teachers as to how fundamental filial therapy concepts and language needed to be modified for use with this special population of teachers and students. To take just one example among many, when setting limits, the language normally used, as in "If you choose to continue to throw sand outside the sandbox, you are choosing to give up playing with the sand for the rest of the session", was deemed by the teachers to be totally unworkable for their students of focus. It was their judgment that deaf and hard of hearing children simply do not have the fundamental language ability to understand this hypothetical "if this/then that" kind of logic or language. The language needed to be much more concrete, the logic much simpler. There was much discussion as to whether any of the students could comprehend the words "choose," "choice," or "decide." Together it was decided that the teachers needed to be much more direct and concrete in their choice of words when setting limits.

Thus, words akin to these were used, communicated either verbally, or with words and sign: "You pick (or decide). Keep sand in the box. Or throw outside. Throw outside, no more

play with sand. Keep inside, play with sand”. While initially sounding more directive, the consensus was there was no other way to communicate what the teacher needed to say in this situation. In playroom sessions with the students, this rework of language and logic appeared to work well. Hence, a portion of every class session was devoted to the modification of the traditional filial therapy conceptual skills and language so as to make them workable for this particular group of teachers and students. More examples will follow in the next section.

#### Session by Session Outline and Modifications of the Landreth (1991) Filial Therapy Model

What follows is what has become the conventional outline of the Landreth (1991) filial therapy training sessions, including modifications used in this research project. The experimental group teachers were presented the totality of what is considered the usual filial therapy training curriculum. However, the material was presented and modified as necessary to fit the needs of these preschool teachers of deaf and hard of hearing children and their particular students of focus. From the beginning, discussion with the teachers underscored the reality that the student’s delays in the acquisition of language and communication skills made modifications necessary.

#### Training Session One

The researcher began by giving an overview of the training sessions and the proposed schedule for the 10 weeks of class instruction. Goals of the filial instruction were explained, including a brief outline of the research design and the primary research hypotheses of the study. Unlike most parents in filial therapy training, throughout the project, the teachers maintained a genuine interest in the research goals and what the researcher hoped to learn from the study and how the study might positively impact their future work with students. This

genuine intellectual interest appeared to facilitate markedly the conjoint effort of working together to modify the curriculum to fit their actual needs.

The researcher briefly described the primary skills to be learned that constitute the foundation of filial therapy skills training: reflective listening, including tracking play behaviors and learning to recognize and respond to the feeling/affective aspect of their student's play; giving choices and allowing the student self-direction in the sessions; setting limits, while allowing the child to assume responsibility for the choices made; and conveying genuine empathy and acceptance of the child as a person, regardless of the child's behavior.

The researcher showed a videotape of Carol Izzard's early work demonstrating that all children are born with certain innate and universal emotions, that these emotions are displayed externally in the child's facial expression and bodily presentation, and that the child's external display of emotion is matched by an internal motivational state that is congruent with the external display of emotion.

The researcher explained the concept of tracking play behaviors and the feelings that accompany the play behaviors. It was explained that communication occurs concurrently at both a content (what gets talked about, or what the child does with a particular toy in the playroom), as well as an emotional level (how the child does whatever he or she does with a toy, the affective aspect of the communication). This presentation spurred a lively discussion about the language and emotional delays seen in deaf and hard of hearing children, and how these often get reflected in the lack of general social skills in the classroom and on the playground. Deaf and hard of hearing children often struggle to read and respond appropriately to the nonverbal emotional dynamic of communication that is so much a part of communication with their peers and teachers. Also, many carry a tremendous level of on-going frustration at not being able to get



themselves understood or translated to the significant others in their world. As a result, as mentioned earlier, they can be overly impulsive and demanding. This discussion offered a perfect opportunity for the researcher to reemphasize the collaborative nature of the research project, again inviting the teachers' insight as to how we together could translate and apply the filial therapy skills in their challenging situation.

The researcher also showed several segments of videotape of actual play therapy sessions with hearing children. The tapes illustrated how to track the child's play behavior in the classroom, and how to begin to pay attention and reflect the emotional import of this behavior.

It was apparent to the researcher from the outset that it would be challenging to help the teachers lay aside their well-developed directive, instructive, teaching mode when being with their student of focus in the playroom. These particular teachers of deaf and hard of hearing preschoolers appeared to be especially compelled to name objects, explain what and how things work, give succinct answers to students' questions and expand on these answers, often while instructing the child in how to vocalize or sign what they were thinking or feeling. This is what the teachers do all day long. Thus, it was initially challenging to ask them to consider "being with" and following their student of focus, rather than taking the lead to engage the student in their usual in-class manner. The teachers were never recalcitrant; they merely required workable reasons with supportive examples from videotape and prior research to help them understand that the key to connecting emotionally in meaningful ways with their student lay in learning new ways to be with the child, on the child's most natural turf, allowing the child to express self through his or her most natural medium, play.

Following an initial roleplay in which the researcher first functioned as the teacher/therapeutic agent with an actual teacher assuming the role of a student, the group divided

into three small groups. In the small groups, using toys provided for the purpose, pairs of teachers practiced reflective listening, with one role playing the teacher, and the other the student. After five minutes, the roles were reversed, so that each got to experience the teacher and child role. When the exercise was finished, the teachers verbally processed their experience of assuming the different roles. The researcher facilitated this discussion, taking care to include those teachers who were more reticent to share. The facilitation of group process, especially allowing opportunity for each teacher to share thoughts, insights, perceptions, and feelings, the researcher judged to be a cornerstone of the training process. This reemphasizes the importance of the notion that teaching the filial therapy skills is only one aspect of instruction. Skillfully facilitating the group process appeared to be as important as imparting information to the overall leading of this group of teachers in this situation.

Since the teachers in the Callier preschool already knew each other from working together daily, minimal time was spent with their introductions to each other. However, they introduced themselves to the researcher by telling the age group they taught, their background and training for their job, and their years of experience. Also, they described their student of focus, whom most had already received parental permission to work with.

Session One ended with the researcher giving a homework assignment. The teachers were to: 1) review the handouts in their assigned notebooks; 2) notice the four basic feelings (mad, sad, glad, and scared) in their child of focus in the week upcoming, 3) practice reflecting these feelings when they recognize them in their student, and 4) write down one example for each emotion on the Reflecting Feelings handout provided for this purpose. The handouts used during this session were: Partners in Play; The 3 R's of the Therapeutic Relationship; Reflecting the Child to the Child; Listening: Four Feelings Faces; and the article: Child's Play: Important

Business (Smith, 1986). The same material, exercises, assignments, and videotapes were presented during the 3-6 pm and 6-9 pm sessions.

### Training Session Two

At the outset, the researcher and teachers reviewed their homework assignment on recognizing and reflecting feelings in their student of focus. Using a volunteer from the group, the facilitator and teacher role played how to respond empathically to the feelings underneath what the teacher was talking about. Then the teacher from this role play and another volunteer did the same role play with each other, in the playroom, using the toys available. The facilitator used the opportunity to rehearse the basics of reflective listening

Emphasizing the need to track play behavior while at the same time paying attention and reflecting the feelings that accompany the play behavior.

Next, the primary guidelines for the practice play times were rehearsed, including the list of “Do’s and Don’ts” in the furnished handout. In the playroom the researcher demonstrated the toys available to the students, while discussing how and why these particular kinds of toys were included in the playroom. This was an opportune time to talk about whether any of the selected toys were inappropriate for the deaf and hard of hearing children, including needed modifications, if any. Together, it was decided to leave the toys as prescribed, and modify them, if necessary, as the teachers had their particular students in the play area. As it worked out, no modifications were made.

The primary three steps for setting limits were presented, including the discussion detailed earlier in this section. A key question was also raised concerning how the teachers were to position themselves in the play area so that they could communicate with their students of focus. How were the students to know if the teacher was “being with” and “hearing” them in and

through their play behaviors and how were the teachers to communicate empathy and acceptance if the student was not aware that the teacher was “talking” to them? The teachers were further concerned that attempting to get the student to look at them while they were responding to the student could be interrupting to the child’s innate flow of play, as well as be directive and controlling for the child. Also, the teachers alerted the researcher to the fact that deaf and hard of hearing persons are taught to be very visually aware and that eye contact is a very vital aspect of communication among the deaf. Further, it was emphasized that, among deaf persons, to break eye contact when communicating is considered an insult. It was decided to see if in fact their concerns were borne out by experience. The teachers could move as they felt the need in order to communicate vocally or with sign and voice. Some of the teachers felt most comfortable moving with the student if he or she moved to the farther end of the play room or chose to play with their backs to the them. Others decided to stay seated in one place, unless it became clear that the student was simply not being able to experience the teacher “being with” or communicating with them in their play. Having never been presented with these issues before, the researcher decided to go with the teachers’ intuition and review the process with the teachers as videotapes of their sessions were presented in future class sessions. This “start from procedures that are known to be efficacious (teaching the skills as recommended in the Landreth (1991) model), and see what appears to work best with the teachers and students” approach seemed indicated by the fact that issues arising from this portion of the teacher/student population had not been explored before.

A similar issue came up with regard to whether the videotapes that were to be reviewed by independent, though qualified, graduate students needed to be translated before they were to be reviewed. In other words, was it necessary for the reviewing students to understand what exactly the teachers were signing to their students, before they could adequately review the

tapes? It was decided that translation was not necessary, as the teachers would be signing as well as vocalizing (the total communication teachers) or simply vocalizing (the auditory communication teachers). However, the teachers were patient and yet insistent that the researcher understand that in American Sign Language, not every word is signed because there is not a sign for every word. Therefore, what the teachers were working to do was take the presented filial therapy skills material offered by the facilitator and “translate” it into workable American Sign Language, while at the same time vocalizing reflections of what they saw being expressed in their students’ play, all the while attempting to grasp and reflect nuance and shades of meaning in the students’ total body presentation.

During the second session, the researcher presented videotapes of hearing children that illustrated the filial skills of “crediting the effort” of the child and setting limits. By way of homework assignments, the teachers were asked to: 1) complete the “Facilitating Reflective Communication” handout; 2) noticing a physical characteristic of their student of focus that they had not seen before; and 3) reading the handout article “The Enchanting Power of Play” (Appendix E). Finally, the teachers were asked to have the first play session with their students of focus in the playroom, before the next meeting. It was decided not to videotape this first session in order to allow the teachers and students freedom from this additional pressure during the first session.

### Training Session Three

To begin these two three hour sessions, a discussion was held regarding the teachers’ responses to the “Facilitating Reflective Communication” handout and homework assignment. This provided the chance to again explore alternative ways to convey in sign language, the essence of the intended facilitative response, particularly in relation to feelings.

The teachers mentioned that the children's play behaviors were limited by their current level of cognitive development and developed language ability. The researcher raised the question as to whether the exposure to the toys, with the "permission" and opportunity to play with them in ways of the students' own choosing, might also stimulate new cognitive and language growth in the students. That is to say, if, as we say, we believe that play is the innate and most natural "language" of children, by this, do we also mean that deaf and hard of hearing preschool children will increase or expand their ability to develop language and communicate by being allowed this opportunity to play, with their teacher focusing his or her undivided attention on the student's play, in the manner suggested, or modified from, Landreth's (1991) filial therapy teaching model? While not a hypothesis of this study, such a question appears relevant for future studies.

The facilitator presented the cluster of skills entitled "Returning Responsibility to the Child" (Appendix E) and showed video tapes that demonstrated the following skills: 1) allowing the child to lead the play session; 2) crediting the child's effort (noticing and responding to the effort, not the product of the effort); 3) resisting the impulse to judge or "grade" the product of the child's efforts; 4) returning to the child responsibility for his or her own decision making; 5) resisting the impulse to ask questions, give answers, teach, or elaborate beyond what the child initiates, responses to his or her play behaviors; 6) resisting the impulse to name or try to teach the child to name particular toys, during the sessions, unless the child names them first. Again, role play was used as part of the teaching process, to illustrate the teaching points. Then a discussion of the teachers' questions, including adaptive procedures, was held, again working to discover appropriate language for the students' in-playroom needs. The researchers and teachers worked to shorten to their essence the teachers' facilitative responses to the students. As an example, instead of attempting to communicate the conditional sense of "Looks like you might

be feeling happy playing with that dinosaur”, or ask the question “Are you happy playing with that dinosaur?” as the teachers were inclined, they decided to respond “You look happy...the dinosaur is fun...you like playing with it”. Finally, the teachers’ first play session with their students of focus was discussed, making sure that each got personal attention from the facilitator and the other class members. Particular attention was given to how the teachers felt about their first efforts with their students. The researcher told the teachers that they would be videotaped during the upcoming week’s session in the playroom. For homework, the teachers were asked to: 1) notice how their student may attempt to avoid responsibility for their own choices and shift it to them, as well as how they may allow themselves to get pulled into taking responsibility; 2) read the handouts for the upcoming week: “Do’s and Don’ts of Play Therapy”; and “Roles and Responsibilities of a Facilitative Adult” (Appendix E).

#### Training Session Four

For this one two-hour session, all 12 of the teachers were present. The session began by viewing portions of the videotapes of the play session of five teachers and their students, then discussing the sessions. The teachers whose videotapes weren’t shown told of their play experiences to the group. The teachers expressed amazement at how readily the students have adapted to being in the playroom and how much they appeared already to love their playtimes. Most of the children had asked to go daily, instead of once a week. One teacher gave the example of her four year-old deaf student grabbing her by the hand and trying to lead her to the playroom. Most of this session was structured around the teachers’ giving positive feedback to one another for their efforts in the playroom. As a result of the group processing of their efforts, that they had done much better than they initially thought and appeared excited to press on. So far, none of the teachers had experienced reluctance in any of the students to enter

the playroom. In fact, several reported dealing with students not want to quit their play when the time was over. The facilitator decided to focus on what he appreciated and thought was workable in these first efforts, leaving discussions for alternative interventions to the following sessions. The attempt was made to relate teachers' specific questions, not just to the asking teacher, but to the entire group. The aim was to facilitate the group experience rather than to respond simply to one teacher's question. The researcher again reviewed the "Do's and Don'ts" filial therapy and reviewed for homework the handout on "Roles and Responsibilities of a Facilitating Adult" (Appendix E).

#### Training Session Five

This two-hour session also combined all the teachers in one group. The researcher discussed the handout "When Setting the Limits Doesn't Work" (Appendix E). The rest of the session was spent looking at portions of videotapes not viewed from last week and discussing the teachers' play sessions of the week just past. During this session, the facilitator began to make concrete suggestion for alternative ways to respond to the students' play. The teachers also joined the process by making alternative suggestions. As expected, in many instances, their reflections and suggestions helped them buy in to the process and further their own development. Again, the group sharing appeared to be as important as the actual teaching of the filial skills themselves.

A goal of the facilitator at this point was, by the end of the session, to have viewed a portion of each teacher's videotape of their play sessions. The goal was to check firsthand each teacher's initial progress in implementing the beginning filial therapy skills and their overall sense of being with their student.



Opportunity was provided to discuss problems that may have arisen thus far in the teachers' play sessions. One teacher reported that her child was scheduled to have cochlear implant surgery (to facilitate his hearing) and that she had worked out a schedule with his mother so that he would not miss any scheduled play sessions. This sort of planning ahead and extra work typified the teachers' ongoing commitment to their students and to learning the basic filial therapy skills.

Several teachers expressed the concern that their students weren't "doing much" with the toys during the playtimes. This offered the opportunity to emphasize again the "being" versus "doing" aspect of the filial process and to clarify that their job was not to lead, as in the classroom, but to follow the child's lead.

A lively discussion then followed concerning the cultural differences between Caucasian and African American parenting styles. In particular, the concept of allowing the child to lead is particularly foreign, especially among lower socioeconomic, less educated groups of African Americans. One of the African American teachers offered that the more directive, less-empathic, "do it because I said do it" relational style may grow out of a need to protect children from more immediate concrete danger. Allowing the child the ability to choose, may result in the child's being hurt in more actual situations. Thus, to allow the child to determine the direction of play in the playroom was swimming upstream. Nevertheless, she, and the other African American teachers, were willing to work with it to see how their students would respond. The homework assignment was to once again review the handouts on "Techniques of Discipline that Work", and to read "Safe Person Safe Place Safe Process" and "The Risk of Rewards" (Appendix E).

### Sessions Six Through Ten

These sessions followed the general established format in which: 1) teachers reported on their assigned homework as class began; 2) teachers discussed the most recent play session with their students with the group; or 3) videotape portions of each teacher's play session was presented and discussed by the group, with care being given to offer encouragement, suggestions, and support from the facilitator and other teachers; 4) special attention was given to the teachers' mastery of core filial skills, with discussion of how these skills could be transferred and generalized to the classroom and their other students; 5) teachers and the facilitator discussed leaving the playroom equipped and available for teachers to use with not only their students of focus, but also other students they believed might benefit for the play therapy experience, after the research project was over. During the final sessions, the facilitator invited the teachers to share with the entire group their success stories concerning their students of focus and playroom experience, as a way of anchoring the acquisition and application of their newly-learned skills.

### Training Session Six

During these two three-hour sessions the researcher began to invite the teachers to track and report on their own thoughts and feelings, as they were being with the students in the playroom, thus adding one more level of "being aware" and reporting on their training experience. In reviewing the videotapes with the teachers and group, the facilitator began to stop the tape at strategic moments and invite the teachers to process what they were thinking and feeling at that moment. The goal here was to broaden their experience with the student to the point of beginning to gently probe their own internal motivation for responding to the student in the way they had. This lead to a general discussion of how, despite professional training, one

tends to respond unconsciously and reflexively the way he or she perceived she was responded to by his or her caretakers as a child. Without getting too personal and violating professional boundaries, the goal was to make the teachers aware of countertransference issues and how these can negatively impact those to whom they respond. Lively discussion followed with a number of the teachers recognizing and relating how they had unconsciously projected onto the student, some of their own personal issues. Discussion as to how they could have responded more effectively followed.

The facilitator highlighted the handout “Praise vs. Encouragement” (Appendix E) and called attention to the next homework assignment.

### Training Session Seven

This two hour, all-present meeting had as its primary focus common problems the teachers were experiencing with their students and possible solutions. Several of the teachers reported that their most common difficulty was having to tell the students that they could not go daily to the playroom, much to the children’s disappointment. A concern was how to deal with parents who, though giving permission for their child to take part in the research study, were sending their children to school, and thus to the play sessions, without their hearing aids. This was making an already difficult task more challenging. One child who appeared very workable in the playroom, and who seemed to thrive on the one-to-one focused attention of his teacher while in the playroom, was still being impulsively aggressive on the playground, as well as still trying to harm the class pets in the classroom. Additional interventions were discussed, including a possible neurological evaluation. In addition, portions of five videotapes of sessions were viewed and discussed by the group. Verbal reports of sessions were shared by the teachers whose videotapes were not considered.

### Training Session Eight

This two-hour, all-present meeting followed the now-familiar format of reviewing as many videotapes as possible, while inviting all the teachers to share in offering encouragement and possible alternate appropriate responses to their peers. The facilitator invited the teachers to recount how their responses had changed with the students of focus, over the course of the project so far. This they did with enthusiasm and excitement. Increasing confidence in their relational ability was evident as they freely offered numerous examples of appropriate filial skills responses in the playroom, but also reported increasing positive behaviors on the students' part in the classroom and on the playground. Examples of these behavioral changes in the students will be offered in the Discussion section of this paper.

### Training Session Nine

This session, two, three-hour classes held in succession, followed the Thanksgiving holiday. In reviewing their play sessions, several teachers reported, and the facilitator noted "regressive behavior" in their students. After discussion, it seemed that at least a significant portion of the regressive behaviors may have been attributed to missing the structure of the daily routine of the classroom, and perhaps the weekly time with their teacher in the playroom, as well as spending more time with what for some of the children appear to be highly dysfunctional families. The teachers were encouraged to get the children into the playroom as soon as feasible, and, if needed and possible, to see the child an additional time in the playroom. This suggestion was met with enthusiasm. The predominance of regressive play behaviors following the holiday reinforces the notion that teachers of deaf and hard of hearing children

have more of an emotional impact, and therefore, potentially helpful emotional relationship with their students, than their peers who teach hearing children.

### Training Session Ten

During this final session, the researcher reviewed the core filial therapy skills with the teachers. Discussion of the teachers' videotaped play sessions followed, but the teachers were asked to critique their own videotape and share what they appreciated and what they would change about their responses to the students. A goal of the facilitator was to allow time for looking at videotape from each teacher. The teachers were then invited to share with the group changes they had noted in themselves and their student of focus during the course of the research project. This they did with genuine enthusiasm and appreciation. Then the facilitator invited class members to recount changes they had noted each of their peer teacher's responses to their student of focus outside of the playtimes, as well as any changes in behavior they had seen in that teacher's student of focus. During this session, the researcher announced that he had decided to leave the playroom equipped after the conclusion of the project, and that several teachers already had plan to continue their weekly sessions with their student. Additionally, two teachers had plans to bring other students from their classrooms for play sessions. These students had not been a part of the experimental group and thus, had not participated in the weekly sessions.

### Facilitator

The filial therapy training group in this study was facilitated by the researcher. The researcher is a Licensed Marriage and Family Therapist in the State of Texas, Registered Play Therapist-Supervisor, an Approved Supervisor of Marriage and Family Therapists in Texas, an Approved Supervisor of Licensed Professional Counselors in Texas, and a Fellow of the

American Association of Pastoral Counselors. He is an Ordained Presbyterian Clergyman in the Presbyterian Church USA (PCUSA). He has been a play therapist for twenty years and a filial therapy facilitator for sixteen years. His course requirements for the doctoral degree at the University of North Texas included an introduction to play therapy course, an advanced play therapy course, a filial therapy course, a doctoral level practicum in play therapy, and a doctoral internship in play therapy. His private practice in play therapy includes providing therapy services to children, adolescents, adults, families. He regularly lead filial therapy groups with parents and teaches, trains, and supervises other professionals in the practice of play therapy and filial therapy.

He has been a keynote speaker in play therapy, group play therapy with children, and filial therapy at state and national play therapy conferences. Together with his wife and business partner, Dr. Nancy Smith, he has co-authored a chapter on group play therapy with children and produced two video training tapes in play therapy that are used in graduate play therapy programs in the U.S. and abroad.

### Analysis of Data

Subsequent to the collection of the pretest and posttest data, the CBC/C-T and SEAI were blind-scored by a research assistant and double-checked by an additional research assistant. The pre and post-training videotapes of teacher-student play sessions were not rated until completion of the study to insure that the raters did not know which they were rating, a pre-training or post-training session, or an experimental or non-treatment comparison group session. Three counseling departmental doctoral students and one post-doctoral adjunct professor, each with advanced training and course work in play therapy and filial therapy, blind scored the videotapes over a three-week period. Inter-rater reliability was established during three one and a

half-hour training sessions. These sessions were held prior to the beginning of the rating process, at the mid-point, and the conclusion of the tape rating process. In order to follow the procedures recommended by Stover et al. (1971), training included discussions and the collaborative rating sessions. Cronbach's alpha was used to report inter-rater reliability. The resulting reliability coefficients are presented in Table 2.

Table 2

*Interrater reliability coefficients of concordance for coding of the Measurement of Empathy in Adult-Child Interaction scales*

Variable	Pretest Reliability Coefficient	Posttest Reliability Coefficient
Communication of Acceptance	.9475**	.9988***
Allowing Self-Direction	.9946**	.9985***
Parental (Teacher) Involvement	.9525*	.9806***
Total Empathy	.9503**	.9974***
* $p \leq .01$ . ** $p \leq .005$ . *** $p \leq .0001$		

For the purpose of statistical analysis, data from all of the teachers who received filial therapy training was pooled to form the treatment group. The pooled data was then placed into the computer and analyzed by the researcher using SPSS 9.0 for Windows (Stangor, 1998).

An analysis of covariance (ANCOVA) was computed to test the significance of the difference between the experimental group, the non-treatment comparison group, and the within groups variance, using the pretest scores as the covariate, and the posttest scores as the dependent variable, on the adjusted posttest means for each hypotheses of scores as measured by the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired

Students (SEAI), the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T), and the Measurement of Empathy in Adult-Child Interaction (MEACI). The posttest indicated in each of the hypotheses was used as the dependent variable and the pretest as the covariant in each case. In order to statistically equate the non-treatment comparison and experimental groups, ANCOVA was used to adjust the group means on the posttest on the basis of the pretest. The level of significance was set at .05 to test the significance of difference between means. The hypotheses were retained or rejected on the basis of the ANCOVA.



## CHAPTER III

### RESULTS AND DISCUSSION

This chapter presents a description of the statistical analyses performed the specific results of each hypothesis, consistent trends identified in the analysis of the data, a discussion of the potential meaning and implications of the findings, and recommendations for future research.

#### Results

The results of this study are presented in the order in which the hypotheses were tested. Analyses of Covariance (ANCOVAs) were performed on hypotheses 1-13. A level of significance of .05 was established as a criterion for either retaining or rejecting the hypotheses. The basic assumptions of ANCOVA were tested and as follows: 1) a regression between the dependent variables (posttest scores) and covariates (pretest scores) within each of the two groups revealed parallel slopes of regression lines across groups for the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) and the Measurement of Empathy in Adult-Child Interaction (MEACI). Slopes of regression lines across groups of the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) revealed parallel slope of regression lines across the groups for two of the variables evaluated. The homogeneity of regression assumption was not violated on these groups. However, while the assumptions for ANCOVA were not violated for the third variable, there was a notable interaction between the treatment effects and the covariate. Therefore, the results for this ANCOVA may be questionable. 2) Levine's Test of Variance indicated that some pairs of groups had heterogeneous parings, but because each group was the same size ( $N=12$ ), there were no significant consequences to the results of the ANCOVAs; 3) a check of the covariates revealed that they do not correlate highly with the treatment effects, with the exception of the

above-mentioned variable of the SEAI.

Inter-rater reliability was checked using correlation matrices for each rater on each variable of the Measurement of Empathy in Adult-Child Interaction (MEACI). Table 2 presents the results.

### Hypothesis 1

The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Total Empathy subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

Table 3 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 4 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 3

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Total Empathy*

	<u>Experimental Group</u>		<u>Non-Treatment Comparison Group</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	44.313	23.000	53.792	50.000
SD	9.268	4.987	9.943	7.987
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates an increase in total empathy.

Table 4

*Analysis of covariance data of the experimental filial therapy teachers' group and non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Total Empathy*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	6.920E-03	1	6.920E-03	.000	.990	.050	.138E-05
Treatment Effects	3209.912	1	3209.912	69.084	.000*	1.000	.638
Error	975.743	21	46.464				.194
Total Cases	5031.750						

\* $p < .001$

Table 4 shows that the  $F$  ratio for the main effects was significant at the .001 level,  $F(1, 21) = 69.084$ ,  $p < .001$ , indicating a significantly greater increase in the experimental group teachers' ability to express empathy as measured by the MEACI as compared to the control group. On the basis of this data, hypothesis 1 was retained. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is large (.638).

### Hypothesis 2

The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Communication of Acceptance subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

Table 5 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 6 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 5

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Communication of Acceptance.*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	15.471	9.792	17.125	17.667
SD	2.366	2.903	2.399	3.667
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates an increase in communication of acceptance.

Table 6

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Communication of Acceptance.*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	11.499	1	11.499	1.054	.316	.165	.019
Treatment Effects	372.122	1	372.122	34.103	.000*	1.000	.607
Error	229.147	21	10.192				.374
Total Cases	612.470						

\* $p < .001$

Table 6 shows that the  $F$  ratio for the main effects was significant at the .001 level,  $F(1,21) = 34.103$ ,  $p < .001$ , indicating a significantly greater increase in the experimental group teachers' ability to express communication of acceptance as measured by the MEACI as compared to the control group. On the basis of this data, hypothesis 2 was retained. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is large (.607).

### Hypothesis 3

The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Allowing the Child Self-Direction subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

Table 7 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 8 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 7

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Allowing Child Self-Direction*

	<u>Experimental Group</u>		<u>Non-Treatment Comparison Group</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	18.042	8.542	22.917	20.792
SD	4.197	2.545	4.044	3.974
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates an increase in allowing child self-direction.

Table 8

*Analysis of covariance data of the experimental filial therapy teachers' group and non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Allowing Child Self-Direction*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	7.595	1	7.595	.672	.422	.123	.007
Treatment Effects	579.826	1	579.826	57.298	.000*	1.000	.506
Error	237.363	21	11.303				.207
Total Cases	1145.333						

\* $p < .001$

Table 6 shows that the  $F$  ratio for the main effects was significant at the .001 level,  $F(1,21) = 57.298$ ,  $p < .001$ , indicating a significantly greater increase in the experimental group teachers' acceptance of behavioral willingness to follow their students' lead rather than attempt to control their students' behavior as measured by the MEACI as compared to the control group. On the basis of this data, hypothesis 3 was retained. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is large (.506).

#### Hypothesis 4

The experimental group of teachers who receive filial therapy training will attain a significantly lower mean score on the Involvement subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the non-treatment comparison group.

Table 9 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 10 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 9

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Involvement.*

	<u>Experimental Group</u>		<u>Non-Treatment Comparison Group</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	11.917	6.548	13.833	12.542
SD	4.507	.690	4.643	3.130
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates an increase in involvement.

Table 10

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Involvement.*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	2.431	1	2.431	.462	.504	.099	.007
Treatment Effects	221712	1	221.712	42.125	.000*	1.000	.662
Error	110.528	21	5.263				
Total Cases	335.000	23					

\* $p < .001$

Table 10 shows that the F ratio for the main effects was significant at the .001 level,  $F(1,21) = 42.125$ ,  $p < 0.001$ , indicating a significantly greater increase in the experimental group teachers' attention to and participation in their students' activity as measured by the MEACI as compared to the control group. On the basis of this data, hypothesis 4 was retained. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is large (.662).

### Hypothesis 5

Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Total Behavior Problems subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

Table 11 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 12 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 11

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher-Report Form (CBC/C-T) subscale: Total Behavior Problems.*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	29.333	15.750	34.750	29.167
SD	25.202	17.454	16.421	17.209
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates a decrease in total behavioral problems.

Table 12

*Analysis of covariance data of the experimental filial therapy teachers' group and non-treatment comparison group on the Child Behavior Checklist/Caregiver-Teacher Report Form subscale: Total Behavioral Problems*



Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	5430.022	1	5430.022	93.938	.000	1.000	.703
Treatment Effects	522.695	1	522.695	9.042	.007*	.818	.061
Error	213.895	21	57.805				.157
Total Cases	7723.958						

\* $p < .007$

Table 12 shows that the  $F$  ratio for the main effects was significant at the .007 level,  $F(1,21) = 9.042$ ,  $p < .007$ , indicating a significantly greater decrease in the experimental group students' Total Behavior Problems as measured by the CBC/C-T as compared to the control group. On the basis of this data, hypothesis 5 was retained. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is in the medium range (.061).

#### Hypothesis 6

Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Internalizing Behavior subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

Table 13 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 14 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

#### Table 13

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher-Report Form (CBC/C-T) subscale: Internalizing Behavior.*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	6.917	2.333	8.167	6.917
SD	5.452	2.462	6.322	5.543
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates a decrease in internalizing behaviors.

Table 14

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher Report Form subscale: Internalizing*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	249.687	1	249.687	34.071	.000	1.000	.471
Treatment Effects	88.773	1	88.773	12.114	.002*	.913	.993
Error	153.896	21	7.328				.291
Total Cases	529.625						

\* $p < .002$

Table 14 shows that the F ratio for the main effects was significant at the .002 level,  $F(1,21) = 12.114$ ,  $p < .002$ , indicating a significantly greater decrease in the experimental group students' Internalizing Behaviors as measured by the CBC/C-T as compared to the control group. On the basis of this data, hypothesis 6 was retained. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is large (.993).

#### Hypothesis 7

Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Externalizing Behavior subscale of the Child Behavior Checklist/Caregiver-

Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

Table 15 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 16 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 15

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher-Report Form (CBC/C-T) subscale: Externalizing Behavior.*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	14.500	8.667	18.500	14.500
SD	14.994	11.007	10.014	8.437
Total Cases	12	12	12	12

Note: A decrease in mean score indicates a decrease in externalizing behaviors.

Table 16

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher Report Form subscale: Externalizing*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	1848.445	1	1848.445	145.263	.000	1.000	.797
Treatment Effects	51.109	1	51.109	4.016	.058	.481	.022
Error	267.221	21	12.725				.115
Total Cases	2319.833						

Table 16 shows that the F ratio for the main effects was not significant at the .05 level,  $F(1,21) = 4.016$ ,  $p > .05$ , indicating there was not a significantly greater decrease in the experimental group students' Externalizing Behavior as measured on the CBC/C-T as compared to the control group. On the basis of this data, hypothesis 7 was rejected. Also, using Cohen's (1988) reference for effect size, it is evident in the analysis that the effect size is small (.022).

#### Hypothesis 8

Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Anxious/Depressed subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) than will students in the non-treatment comparison group.

Table 17 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 18 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 17

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher-Report Form (CBC/C-T) subscale: Anxious/Depressed.*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	1.750	.833	2.083	1.750
SD	1.765	1.193	2.193	2.051
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates a decrease in anxious/depressed behaviors.

Table 18

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher Report Form subscale: Anxious/Depressed*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	43.745	1	43.745	50.552	.000	1.000	.653
Treatment Effects	2.758	1	2.758	3.187	.089	.399	.041
Error	18.172	21	.865				.271
Total Cases	66.958						

Table 18 shows that the F ratio for the main effects was not significant at the .05 level,  $F(1,21) = 3.187$ ,  $p > .05$ , indicating there was not a significantly greater decrease in the experimental group students' Anxious/Depressed problems as measured by the CBC/C-T as compared to the control group. On the basis of this data, hypothesis 8 was rejected. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is small (.041).

### Hypothesis 9

Students who receive filial therapy training will attain a significantly lower mean score on the Withdrawn subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will student in the non-treatment comparison group.

Table 19 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 20 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 19

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher Report Form (CBC/C-T) subscale: Withdrawn*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	3.417	.917	3.583	3.083
SD	3.118	1.311	3.655	2.539
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates a decrease in withdrawn behavior.

Table 20

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher Report Form subscale: Withdrawn Behavior*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	52.859	1	52.859	30.022	.000	.999	.445
Treatment Effects	26.207	1	26.207	14.884	.001*	.957	.222
Error	36.974	1	1.761				.313
Total Cases	118.000						

\* $p < .001$

Table 20 shows that the  $F$  ratio for the main effects was significant at the .001 level,  $F(1,21) = 14.884$ ,  $p < .001$ , indicating there was a significantly greater decrease in the experimental group students' Withdrawn Behavior problems as measured by the CBC/C-T as compared to the control group. On the basis of this data, hypothesis 9 was retained. Also, using Cohen's (1988) reference for effect, it is evident that the effect size in the analysis is in the medium range (.222).

#### Hypothesis 10

Students whose teachers receive filial therapy training will attain a significantly lower mean score on the Aggressive Behavior subscale of the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) posttest than will students in the non-treatment comparison group.

Table 21 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 22 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 21

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher Report Form (CBC/C-T) subscale: Aggressive Behavior.*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	9.417	6.667	11.833	9.167
SD	11.720	10.094	7.744	7.371
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates a decrease in aggressive behavior.

Table 22

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Child Behavior Checklist Caregiver/Teacher Report Form subscale: Aggressive Behavior*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	1492.686	1	1492.686	138.918	.000	1.000	.850
Treatment Effects	1.452	1	1.452	.135	.717	.064	.001
Error	225.647	21	10.745				.123
Total Cases	1755.833						

Table 22 shows that the F ratio for the main effects was not significant at the .05 level,  $F(1,21) = .135$ ,  $p > .05$ , indicating there was not a significantly greater decrease in the experimental group students' Aggressive Behavior problems as measured by the CBC/C-T as



compared to the control group. On the basis of this data, hypothesis 10 was rejected. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is negligible (.001).

### Hypothesis 11

Students whose teachers receive filial therapy training will receive a higher mean score on the Sociable, Communicative Behaviors subscale of the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) posttest than will students in the non-treatment comparison group.

Table 23 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 24 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 23

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) subscale: Sociable, Communicative Behaviors*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	2.840	3.352	3.315	3.387
SD	.984	.440	.305	.311
Total Cases	12	12	12	12

Note: An increase in the mean score indicates an increase in sociable, communicative behaviors.

Table 24

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students subscale: Sociable/Communicative Behaviors*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	.496	1	.496	3.853	.063	.465	.154
Treatment Effects	.02183	1	.02183	.170	.685	.068	.007
Error	2.702	21	.129				.843
Total Cases	3.205						

Table 24 shows that the F ratio for the main effects was not significant at the .05 level,  $F(1,21) = .170$ ,  $p > .05$ , indicating there was not a significantly greater increase in the experimental group students' Sociable, Communicative Behaviors as measured by SEAI as compared to the control group. On the basis of this data, hypothesis 11 was rejected. Also, using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is negligible (.007).

#### Hypothesis 12

Students whose teachers receive filial therapy training will receive a lower mean score on the Impulsive, Dominating Behaviors scale on the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) posttest than will students in the non-treatment comparison group.

Table 25 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 26 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 25

*Mean Scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Meadow-Kendall Social Assessment Inventory for Deaf and Hearing Impaired Students (SEAI) subscale: Impulsive, Dominating Behaviors*

	<u>Experimental Group</u>		<u>Non-Treatment Comparison Group</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	2.272	2.950	2.962	2.880
SD	1.191	1.103	.514	.632
Total Cases	12	12	12	12

Note: An decrease in the mean score indicates a decrease in impulsive, dominating behaviors.

Table 26

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students subscale: Impulsive/Dominating Behaviors*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	3.930	1	3.930	5.952	.024	.643	.220
Treatment Effects	.778	1	.778	1.180	.290	.179	.043
Error	13.848	21	.659				.778
Total Cases	17.802						

Table 26 shows that the F ratio for the main effects was not significant at the .05 level,  $F(1,21) = 1.180, p > .05$ , indicating there was not a significantly greater decrease in the experimental group students' Impulsive, Dominating Behaviors as measured by the SEAI as compared to the control group. On the basis of this data, hypothesis 12 was rejected. Also, using

Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is small (.043).

### Hypothesis 13

Students whose teachers received the filial therapy training will receive a lower mean score on the Anxious, Compulsive Behaviors scale of the Meadow-Kendall Social-Emotional Assessment for Deaf and Hearing Impaired Students (SEAI) posttest than will students in the non-treatment comparison group.

Table 27 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 28 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores, as well as the observed power and treatment effects.

Table 27

*Mean scores of the experimental filial therapy teachers' group and non-treatment comparison group on the Meadow-Kendall Social-Emotional Assessment for Deaf and Hearing Impaired Students (SEAI) subscale: Anxious, Compulsive Behaviors*

	<u>Experimental Group</u> (N=12)		<u>Non-Treatment Comparison Group</u> (N=12)	
	Pretest	Posttest	Pretest	Posttest
Mean	3.463	3.612	3.570	3.627
SD	.492	.447	.592	.381
Total Cases	12	12	12	12

Note: A decrease in the mean score indicates a decrease in anxious, compulsive behaviors.

Table 28

*Analysis of covariance data of the experimental filial therapy teachers' group and the non-treatment comparison group on the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students subscale: Anxious/Compulsive Behaviors*

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F	Observed Power	Eta Squared
Covariate	.478	1	.478	3.035	.096	.383	.126
Treatment Effects	.00147	1	.00147	.007	.936	.051	.0003
Error	3.308	21	.158				.874
Total Cases	3.787						

Table 28 shows that the F ratio for the main effects was not significant at the .05 level,  $F(1,21) = .007$ ,  $p > .05$ , indicating there was not a significantly greater decrease in the experimental group students' Anxious, Compulsive Behaviors as measured by the SEAI as compared to the control group. On the basis of this data, hypothesis 13 was rejected. Also, using

Cohen's (1988) reference for effect size, it is evident in the analysis that the effect size is negligible (.0003).

## Discussion

The results of this study strongly suggest the effectiveness of filial therapy in training preschool teachers of deaf and hard of hearing children to become therapeutic agents of change with their preschool students. Of the 13 research hypotheses, seven were retained, and six were rejected, while an additional hypothesis approached significance. The findings of this study indicate that the experimental group teachers significantly improved their therapeutic relational skills with their students as measured by the different domains of the Measurement of Empathy in Adult-Child Interaction (MEACI). Likewise, the students significantly improved their behavior as a result of the teachers' changed responses. The students' improvements are also reflected on several domains of the Child Behavior Checklist Caregiver/Teacher Report Form (CBC/C-T). An interpretation of the scores is provided in the following section. Also, anecdotal reports from the participating teachers in the experimental group will be offered as well as recommendations and implications for future research.

### Empathic Behavior: A Function of Communication of Acceptance, Allowing the Child Self-Direction and Involvement in Teacher-Student Interactions

The teachers in the filial therapy experimental group attained a significant decrease ( $p < .001$ ) on the Total Empathy subscale posttest of the MEACI with a large effect size (.638) on the basis of ratings of videotaped play sessions with their students. A decrease on the subscales of the MEACI indicates a change in the desired behavior. The Total Empathy scale of the MEACI is comprised of the total scores of three subscales: Communication of Acceptance (reflection of the student's play behaviors and accompanying feelings in an accepting manner); Allowing the

Child Self-Direction (allowing the student to decide the direction and manner of play as opposed to controlling the play); and Involvement (being with and attending to the student in a manner that conveys full involvement primarily for the child's sake). The findings of this study suggest that the filial therapy training enabled the teachers in the experimental group to significantly improve their ability to: 1) convey empathy to their students, 2) communicate acceptance to their students, and 3) allow the student to be self-directive, which entailed following the child's lead rather than controlling or directing the child, 4) maintain involvement with the student without superseding the student's autonomy.

#### Communication of Acceptance: A Dimension of Empathy

The teachers of the experimental group showed a significant decrease ( $p < .001$ ) on the Communication of Acceptance subscale posttest in comparison to the pretest score on the MEACI and realized a large effect size (.607). Again, a decrease in the mean score indicates an increase in the desired behavior. The major element in the communication of empathy is the verbal expression of acceptance, according to Stover, B. Guerney, and O'Connell (1971), authors of the MEACI. Their research indicated that verbal expressions of acceptance did not usually occur during spontaneous transactions between parents and their children.

A similar finding was confirmed in the present study of teachers and their deaf or hard of hearing students of focus. A review of the pretest videotapes of both the experimental and non-treatment comparison groups indicated that a substantial majority of the teachers exhibited an initial tendency to view the student play sessions as a continuation of in-class teaching time, an extended period of "teachable moments." Since teachers of deaf and hard of hearing preschoolers view teaching their students how to interact and communicate as a primary responsibility (Schirmer, 2000), this tendency was understandable. Hence, the pretest videotapes

were full of teacher responses such as: “What’s that?” (when a child looked interested in a toy); “Can you say ‘car’? Try to say (or sign) ‘car’ with me. You know what cars do, don’t you? We use them to go places” (when a child picked up a toy car). Or, “What can you do with it? Do you want me to play with you? Here, let me show you how you play with it. Look here; try it this way. We haven’t tried this yet. I’ll help you. First, put that doll in the doll house. Oooh, isn’t this fun! It’s fun to play together!”

There were almost no reflections of feeling responses, the chief behavioral indicator of acceptance on the MEACI, among the pretest videotapes of the experimental and control group teachers and their students. While the posttest videotapes of the non-treatment comparison group continued this pattern, the responses of the experimental group did not.

The significant improvement in responses of the experimental group teachers is remarkable in that the improvement is based on the judgment of trained professionals acting as blind raters of specific filial therapy skills, as opposed to self-report instruments. According to the raters, the experimental group teachers significantly improved in their abilities to verbally acknowledge acceptance of the students’ play behaviors and feelings.

The findings of this study lend support to earlier investigations that also used the observations of objective raters to evaluate the effectiveness of parent and child changes following filial therapy training (B. Guerney & Stover, 1971; B. Guerney, Stover, & DeMerritt, 1968; Stover & B. Guerney, 1967; Stover et al., 1971). The Stover et al. (1971) study indicated that the decisive factor in enabling significant changes in the child’s behavior was a high level of empathic and accepting behavior on the part of the parents. These findings also reinforce B. and L. Guerney’s early filial foundational principle that parents have a “uniquely powerful



influence” on their child’s development and a “genuine motivation to be a positive force in their children’s lives in a great majority of cases” (L. Guerney and B. Guerney, Jr., 1989, p.345).

As noted in Chapter 1, Andronico and B. Guerney (1969) and B. Guerney and Stover (1971) expanded filial therapy to include the concept of using teachers as therapeutic agents with their students. Also, in L. Guerney and Flumen’s (1970) study with teachers of withdrawn children, the teachers’ ability to convey empathy and acceptance was a determining factor in their students’ improved behavior. More recent literature has also supported the use of filial therapy training with teachers (Bratton & Landreth, 1995; Brown, 2001; Ginsberg, 1984; Landreth, 1999; White, Draper, Flynt, O’Shaughnessy, & Jones, 1997; 1999; 2001). The teachers’ ability to convey empathy and acceptance is central to the teachers and students’ positive changes in behavior in these studies as well.

#### Allowing the Child Self-Direction and Maintaining Appropriate Involvement: A Dimension of Empathy

The results of this study also indicate significant changes in the experimental group teachers’ ability to allow students self-direction and to be appropriately involved with them during play sessions. The teachers in the experimental group exhibited a significant decrease ( $p < .001$ ) on the Allowing the Child Self-Direction subscale posttest in comparison to their pretest score on the MEACI. This indicates a significant improvement in the teachers’ ability to allow their students’ self-direction. The teachers showed a significant decrease ( $p < .001$ ) on the Involvement subscale posttest in comparison to the pretest score on the MEACI, indicating significant improvement in the teachers’ ability to establish and maintain appropriate involvement with the child throughout the play session. Additionally, the effect size for both variables was large, .506 and .662, respectively.

The potential ramifications of these significant changes for teachers of deaf and hard of hearing children are noteworthy. If, as the research suggests, deaf and hard of hearing children experience higher incidences of depression, aggression, anxiety, impulsivity, estrangement, and isolation than their hearing peers (Leigh, Robbins, Welkowitz, & Bond, 1989; Luterman, 1999; Watt & Davis, 1991), it would seem important that their teachers be able to genuinely reflect empathy and acceptance for the student's struggles, while at the same time, know how to be meaningfully involved and allow the students appropriate self-direction.

Anecdotal reports from several teachers demonstrate their acquired filial therapy skills in these areas. Their reports speak to the students' improved behavior in the playroom, in the classroom, and on the playground. One teacher put it this way when speaking of her student of focus, a kindergarten child who, because of his deafness, had almost no understandable spoken language: "Since Raymond did not have his hearing loss identified until he was four years old, he has only been in our school six months. I did not have the opportunity to bond with him the way that I have with the other children in the class. If things did not go his way, he would jump up in the air and land on his bottom, screaming and crying. The crying could last for 45 minutes. The training has been most successful in helping me bond with Raymond. Today, he hugged me this morning, sat in my lap during music time, and ran up and hugged me on the playground. He would never have done this before. He has not had a temper tantrum in a month. He now works through these feelings without jumping and crying. Other teachers have noticed and commented to me on his improved behavior and attitude. He loves special playtime. Often, he asks me if it's time to 'go get the key' (to the playroom)."

Another teacher had this to say: "I chose Eric for my student of focus because he had little eye contact and few signs (little ability or interest in using sign language to communicate),

and was not well bonded with me or the other children. At 18 months he had meningitis which took his hearing. He was on a normal developmental track until then. After a few sessions in the playroom, he started to smile, in and outside the therapy room. Then he began to laugh appropriately at silly activities. He started to play 'peek-a-boo' in the playroom. This was his way of starting to make eye contact. Now he makes eye contact for longer periods of time. He now seeks me out when he has a problem. He is now working hard to learn to talk and sign.”

Though teacher reports on the CBC/C -T and the SEAI are by design subjective and, therefore, may be viewed as lacking objectivity, when combined with the externally rated MEACI (and its very high degree of demonstrated inter-rater reliability), the subjective nature of the two instruments (CBC/C-T and SEAI) did not seem as limiting as they could have been by themselves. In fact, the combination of instruments that provided data obtained solely from the teachers with a very involved, subjective view, with data collected from external raters with a very uninvolved, objective rating criteria appear to offer a more complete understanding of the progress of students in the experimental group.

### Behavior Problems

Children in the filial therapy group demonstrated a significant decrease ( $p < .007$ ) in Total Behavior Problems as measured by the Child Behavior Checklist/Caregiver-Teacher Report Form (CBC/C-T) in comparison to the non-treatment comparison group at the time of posttesting. The significantly lower mean score on the Total Behavior Problems scale indicates a reduction of overall behavioral problems as perceived by the children's preschool teachers. A medium effect size (.061) was attained by the treatment effects.

The CBC/C-T score is a composite score of seven subscales: 1) Emotionally Reactive, 2) Anxious/Depressed, 3) Somatic Complaints, 4) Withdrawn, 5) Attention Problems, 6)

Aggressive Behaviors, 7) and Other Problems. These findings suggest that the overall well being and emotional adjustment of the children in the experimental group were significantly improved as a result of the filial therapy treatment. Such a reduction in overall behavior problems is noteworthy, particularly in light of the high incidence of behavior problems prevalent in deaf and hard of hearing preschoolers (Leigh, Robbins, Welkowitz, & Bond, 1989; Luterman, 1999; Mantanini-Manfredi, 1993; Vernon & Andrews, 1990; Watt & Davis, 1991). Following the conclusion of the study, teachers in the experimental group reported few behavioral problems overall among their students of focus and indicated that other teachers and school administrators noted a reduction in the total number of behavioral problems as well.

This significant reduction in total behavior problems appears noteworthy because behavioral difficulties among deaf and hard of hearing young children are especially prevalent and are thought to be related to their prolonged dependence on primary caretakers (principally parents and teachers) and low self-control (Elliott, Glass, & Evans, 1987; Maxon & Bracket, 1992). Further, deaf and hard of hearing young children are viewed as having great difficulty developing an internal locus of control and experience social delays and isolation (Hindley, 1997). Also, according to Greenburg, Kusche, and Spelz (1991), the development of language is the critical element in the deaf and hard of hearing child's ability to develop internal motivation and external control. Additionally, significant delays in the development of language and communication skills account for much of the frustration and anger that these children either internalize or externalize (Cohen, 1991, as cited in Schirmer, 2000). This being the case, the teachers' identification of fewer problem behaviors suggests that the improved student behavior as perceived by the teachers may indeed be a result of the experimental treatment.

Children in the filial therapy group also demonstrated a significant decrease ( $p < .002$ ) in Internalizing Behaviors as measured by the CBC/C-T in comparison to the non-treatment comparison group at the time of posttesting. The effect size was also significant (.993). The Internalizing Behavior scale of the CBC/C -T consists of four subscales: 1) Emotionally Reactive, 2) Anxious/Depressed, 3) Somatic Complaints, and 4) Withdrawn Behaviors. Each of these subscales represent various types of internalizing behavior that are combined to formulate the Internalizing Behaviors score.

Internalizing behaviors are recognized as defensive behaviors by which individuals attempt to cope and protect self from emotional distress by suppressing perceived painful emotional reactions to problems into the privacy of self. Internalizing behaviors are often precursors to the development of depression, anxiety and emotional withdrawal, all of which have been identified as prevalent in children who are deaf or hard of hearing (Hindley, 1997; Kalivoda, Higbee, & Brenner, 1997). Whereas externalizing behavior problems tend to get noticed and responded to quickly by teachers and adults, internalizing behaviors are not so readily noticed. Hence, they are more likely to go unattended. Due to the high incidence of social isolation, depression and anxiety among deaf and hard of hearing children (Leigh, Robbins, Welkowitz, & Bond, 1989; Luterman, 1999; Watt & Davis, 1991), the reduction in Internalizing Behaviors deserves consideration.

The absence of hearing and the emotional comfort and strength that comes from reciprocal communication is thought to be one factor that causes deaf and hard of hearing children to live more internally focused than hearing children (Alpin, 1987; Maxon & Bracket, 1992). Because the deaf child must operate from an internal world of silence, the child is not able to naturally receive affirmation, information, and emotional contact from others as easily or

quickly as hearing children. In other words, the deaf or hard of hearing child has fewer avenues for connecting with the world beyond self (Maxon & Brackett, 1992). Hence, the difficult task of developing communication skills that come so naturally to hearing children is believed to contribute to increased emotional isolation (Allen, 1986; Bebkö, 1998; Cates, 1991; DeSelle, 1994; Marshark & Clark, 1993). Bat-Chava's 1993 meta-analysis of twenty-two studies showed that some parents and teachers of deaf and hard of hearing children struggle to develop and maintain a workable emotional relationship with their children or students.

The significant reduction of internalizing behaviors in the children in the filial therapy group may be the result of the teachers' focused attention and empathic, reflective listening responses during the student-teacher play sessions. As their teachers communicated more understanding and acceptance non-verbally, verbally, and through sign, it appears that the students in the experimental group felt more secure and free to express themselves openly. Kolod (1994) argued that a fundamental precept of human attachment is that a common language is necessary. Kolod further believed that the lack of a common language, or a less-than fluent common language, could negatively impact the child-primary caretaker relationship in a significant way. Hence, It may be that, because of the filial therapy training, which resulted in the teachers' increased ability to attend with focused attention, empathy, and acceptance to the child's most natural means of communication (play), the experimental group teachers were able to begin to develop this necessary common language, which, in turn, helped to account for the students' significant reduction in withdrawn behaviors.

This same pattern of increased openness and the reduction of defensive behaviors has been verified in filial therapy research studies with child witnesses of domestic violence (Smith,

2001), children of incarcerated parents (Landreth and Lobaugh, 1998), chronically ill children (Tew, 1991), and children with learning disabilities Kale, (1997).

Equally as important as the teacher's newly acquired abilities to sustain emotional connection and convey understanding may be the uniquely structured opportunity that the student play sessions offered for them to freely express self through the medium of child-directed play. Axline (1947) identified play as the child's natural medium of self-expression, describing toys as the words and play as the language of children. According to Landreth (1991), when given the opportunity, children will use play as an avenue to symbolically express the "internal conflicts, emotional turmoil, and uncertainties that are within them" (p.10). Not only were the children in the experimental group allowed to play as they desired, their play was conducted within the warm, caring presence of their teacher, a teacher who was communicating a new level of acceptance and empathic understanding. Again, it appears that the dual combination of child-directed play and the accepting, non-directive presence of the teacher provided the children an avenue of relief that allowed them to be more trusting, thereby reducing their need to internalize distress. The reduction in the students' internalizing behaviors appears to support the viability of the filial therapy treatment with deaf and hard of hearing preschoolers.

In speaking of her four-year-old student of focus and recounting the "firsts" that she experienced with the child in the playroom, one teacher reported: "Maria continues to make positive changes, including many new 'first' time behaviors, during our play sessions. A 'first' this week was her beginning to 'talk' while she played. She initiated a conversation between characters. First, she had one character speak one word sign combined with two gestures and then had the other character answer with one word sign and gestures. She is also beginning to respond to the simplified 'choice language' used in limit setting, both inside and outside of the

playroom. Our relationship has improved because of the many opportunities for positive attention during the play sessions. This gives us a more positive start when we approach each other outside the playroom. Now, she is usually willing to accept limits and is less jealous of others. She is interacting better with her play partner (in class and on the playground) and with other adults. I enjoy being with her now. ”

The results on the Externalizing Behavior scale did not attain statistical significance, however, the children in the filial therapy group demonstrated a very positive trend ( $p < .058$  vs.  $p < .050$ ) in the reduction of Externalizing Behaviors as measured by the CBCL/C-T in comparison to the non-treatment comparison group at the time of posttesting. The effect size realized by the treatment effects was small (.022). This suggests that the experimental group teachers perceived a reduction in externalizing behavior problems in their students, even though the reductions did not attain significance. It is possible that had a larger number of teachers been used, significance would have been attained on the Externalizing Behavior subscale. This inference seems even more likely since a significant reduction was realized on the Total Behavior Problems scale, which is derived from a combination of all subscales. Aggressive and Attention Problem subscales are components of the Total Behavior Problems scale and are the two subscales that combine to obtain the Externalizing Behavior score. Also, it is likely that the small effect size and power may have been increased, since effect size and power are directly proportionate to the sample size and the level of significance chosen by the researcher (Stevens, 2002).

This positive trend, nearing the level of significance, is noteworthy in light of the high incidence of externalizing, acting out behavior problems with young children who are deaf and hard of hearing (Alpin, 1987). As previously noted, deaf and hard of hearing children are prone



to more aggressive, acting-out behaviors than their hearing peers (Greenberg et al., 1991; Hindley, 1997; Kalivoda, Higbee, & Brenner, 1997).

Filial therapy training of parents has been shown to be effective in reducing externalizing, aggressive behaviors among children who commonly display these behaviors, such as child witnesses of domestic violence (Smith, 2001, Tyndall-Lind, 1998; Kot, 1995), children of single parents (Bratton & Landreth, 1994), and children of incarcerated fathers or mothers (Landreth & Lobaugh, 1998; Harris, 1995).

The teachers in the experimental group noted not only a marked reduction in their students' externalizing behaviors, but also an increased willingness to communicate using sign, vocalization, or both. Among deaf and hard of hearing children, externalizing behaviors often emerge in the form of active or passive aggression. This aggression may be related to the children's difficulty with, and possible resistance to communicating in sign or spoken language (Leigh, Robbins, Welkowitz, & Bond, 1989; Watt & Davis, 1991). In this regard, when reflecting on her four year-old deaf student of focus, a teacher said: "Jennifer has a real temper. Last year, if things did not go exactly as she wanted, she would explode. She was very aggressive, hitting, kicking, biting, scratching, and throwing things, including chairs. Many times I had to restrain her and it took forever for her to calm down. *There was no reasoning with her* (researcher's italics). Now that we have had a number of play sessions, I have noticed a deep bonding that is emerging between us. She has begun to seek me out for hugs instead of my having to approach her. She now regulates and modifies her anger and is less reactive in situations that would have set her off last year. I am excited about this new, self-checking behavior; she is now very helpful and considerate to everyone. She sometimes acts like a

mediator when other students are in conflict. This never would have happened last year. I think the filial therapy training is responsible for both of our changes.”

It appears noteworthy in this context that the teacher’s prior attempts to *reason* with this deaf child had been totally ineffective. Talking to, or attempting to reason with a deaf or hard of hearing preschool child is not likely to be successful because of the inherent difficulty in communicating with a deaf, acting out child. In other words, the delayed ability to communicate effectively was likely a big factor contributing to Jennifer’s ongoing feelings of frustration and anger, as well as her tendency to act out aggressively. Also, it appears significant that prior to her teacher’s filial therapy training, applying physical restraints when necessary had not been successful in diminishing Jennifer’s aggressive behaviors. Jennifer’s changes seem to be a direct result of the filial therapy process. It appears that, in the course of the regular student-teacher play sessions, a different quality of emotional relationship emerged between Jennifer and her teacher, one that was more positive both in and outside the playroom. This case suggests the effectiveness of filial therapy in fostering positive relationship changes and a reduction in aggressive, acting out behavioral problems as verified in both quantitative and qualitative research studies. In a qualitative study that investigated the efficacy of using filial therapy to train parents to be therapeutic agents with their children, Bavin-Hoffman (1994) identified an increase in self-control, a decrease in aggression, and improved family relations among children whose parents received filial therapy training. Significant changes were also noted particularly in the areas of interpersonal communication and increased closeness in the parent-child relationship. Also, Smith (2001) determined that intensive filial therapy was effective in significantly reducing externalizing behavior problems and aggressive behaviors with child

witnesses of domestic violence, a population that is prone to adopt the violent, aggressive behaviors of their parents.

Students in the filial therapy group did not demonstrate a significant decrease ( $p > .05$ ) in Anxious/Depressed subscale as measured by the CBC/C-T in comparison to the non-treatment comparison group at the time of posttesting. Also, the effect size realized by the treatment effects was small (.041). This suggests that students whose teachers participated in filial therapy were not perceived by their teachers as exhibiting markedly decreased behaviors associated with symptoms of depression: feelings of hopelessness, helplessness, sadness, irritability, loneliness, nervousness, guilt, fear, or possibly rage, or shame. Initially the lack of significant decrease in anxious and depressed feelings among the students in the filial therapy group was puzzling. As noted earlier, deaf and hard of hearing students often manifest behavioral symptoms of depression and anxiety along with social isolation (Watt & Davis, 1991). Further, since significant decreases were noted on the Withdrawn subscale and the Internalizing scale overall, it was anticipated that there would be an accompanying significant reduction on the Anxious/Depressed subscale.

Also, since it has been shown that children whose parents have participated in filial therapy training have shown significantly fewer anxious and depressed behaviors in their parents' estimation at posttesting (Smith 2001; Landreth & Lobaugh, 1998; Kale, 1997; Bratton & Landreth, 1994), similar results were expected in this study. An evaluation of the Anxious/Depressed test scores revealed a markedly low level of Anxious/Depressed behaviors among students of the experimental group, as perceived by their teachers. None of the individual scores approached even the borderline clinical range of concerns. Six of the total of twelve teachers noted any degree of Anxious/Depressed behaviors in their student of focus. On this

scale, of the six teachers who indicated that their students had any of these behaviors, only two or three of a total of eight items were checked, and of these, virtually all were rated by the teachers to be “Somewhat or Sometimes True”, as opposed to “Very True or Often True”. While several teachers noted a reduction in the number of Anxious/Depressed behaviors at the time of posttest, when compared to pretest, from the outset, there did not appear to be enough Anxious/Depressed behaviors to constitute a difficulty with this group of preschool students.

It appears in the estimation of the participating teachers that anxiety and depression were/are not major issues with their students of focus. A review of their reflections on their experience with the students supported this conclusion as well.

Perhaps the relatively young ages of these students partially accounts for the low incidence of reported anxiety and depressive problems, as the recognition of depressive symptoms is very difficult among young children and correct diagnosis requires specialized expertise and careful questioning of the child’s parents, as well as observation of the child (Goodyear, 2001).

Children in the filial therapy group demonstrated a significant decrease ( $p < .001$ ) on the Withdrawn Behavior subscale of the CBC/C-T in comparison to the non-treatment comparison group at the time posttesting. This means that children who participated in filial therapy decreased behaviors associated with withdrawal and isolation, fewer age inappropriate interactions with peers and adults, as well as decreased emotional and physical distancing of self from others. These statistically significant results paralleled the teachers’ view, shared in the filial training sessions, that the treatment enabled the students of focus to gradually shift from an isolated, defensive frame of reference to a pro- social and interactive frame of reference. The teachers unanimously concurred that the treatment facilitated the children to gradually discard

their tentative, inhibited approach to the world, a most familiar pattern to children with hearing deficits, in order to venture forth with new confidence to embrace the world around them.

The quality of emotional attachment between deaf and hard of hearing children and their parents (Greenberg & Marvin, 1979; Hagborg, 1995; Schirmer, 2000) is believed to contribute to patterns of withdrawal and inwardness. Likewise, Bat-Chava (1993) identified unique difficulties that deaf and hard of hearing children have in developing healthy emotional attachments with their teachers. Hence, among deaf and hard of hearing children, a pattern of isolation can easily evolve into a withdrawn posture which tends to create emotional distance in relationships with others (Bat-Chava, 1993). Thus, the deaf and hard of hearing child who desperately needs emotional and cognitive support from others, is more predisposed to live from an internal frame of reference that is believed to foster internalizing behavior problems (Lederberg, 1991; Marshark & Clark, 1993).

A teacher in the experimental group discussed how a particular three year-old hearing impaired girl, who customarily spoke very little, could not initially grasp the idea that she could decide for herself what and how she wanted to play during her play time. Her teacher explained that “During the end of the play therapy experiment, Sophia began to branch out and play with other toys in the playroom. Simultaneously, in the classroom she began to make friends and play with the other children instead of playing alone. Everyday she is participating more and talking more. I believe our play therapy sessions sparked this new spurt of growth in her development. I think that several other children in my class could benefit from play therapy, just as Sophia has.”

The children in the filial therapy group did not demonstrate a significant decrease ( $p > .05$ ) on the Aggressive Behavior subscale of the CBC/C-T in comparison to the non-treatment

comparison group. This means that the children who participated in filial therapy did not decrease behavior associated with physical and emotional aggression. Though aggressive behavior is generally prevalent in deaf and hard of hearing children (Alpin, 1987; Hindley, 1997; Kalivoda, Higbee & Brenner, 1997), a review of the pretests of children in the experimental group indicated an interesting split in scores. Of the twelve students in the experimental group, an odd range of scores occurred: 1) seven were ranked as having a near absence of aggressive behaviors; 2) one was ranked in the mid-range of normal levels of aggression; 3) one was ranked on the line between the normal and borderline range of scores for clinical concern; 4) two were ranked within the borderline range of scores for clinical concern; and 5) one was ranked within the clinical range of concern (with a score so high, it may have functioned as an outlier). Therefore, nearly half of the scores indicated almost no presence of aggression and nearly half of the scores indicated aggression nearing or within the clinical range. Such a dichotomy in scores may have skewed the results.

A review of the scores of students in the non-treatment comparison group indicated that there were no children who were rated in the clinical range of concern for aggressive behaviors. Although one student was in the borderline range of clinical concern, eight children were within the normal range, and only two (compared to seven in the experimental group) were ranked as having a near absence of aggressive behaviors. Therefore, the lack of statistical significance may be because of the unusual range of the scores more than an indication of the lack of the statistical significance of treatment.

In comparing the pretest with posttest scores of students in the experimental group, two students in the borderline range for clinical concern and one student within the mid-normal range showed a steady trend in reducing aggressive behaviors over the course of the research study.

The only child who was ranked within the clinical range of concern showed a very slight reduction in aggressive behaviors. However, ironically, this child demonstrated virtually no aggressive behavior in the playroom even though he regularly hit other children, attempted to injure class pets, and bit himself in the midst of emotional outbursts.

Several of the teachers anecdotally noted decreased aggressive behaviors in their student of focus within the classroom and on the playground. However, during the teachers' weekly supervision and discussion of videotaped play sessions, there were no reports of overtly aggressive play during student teacher play times. Apparently, among this group of teachers and students in this particular study, aggressive behaviors were not predominant or a pressing difficulty (with the exception of the above-mentioned student).

Still, several of the children did play with the handcuffs, dart gun, rope, alligator, dinosaurs, and other aggressive type toys. Yet their play was self-limiting in terms of aggression. On several occasions one child pointed the loaded dart gun at his teacher, but then smiled broadly and fired it in another direction. Even with little ability to communicate verbally or with sign, his play behavior suggested that he knew the teacher was not for shooting. He was merely having fun and testing her response to his behavior.

Also, students who in the classroom regularly engaged in acting-out, impulsive physical aggression toward themselves, the teachers, and other children did not play aggressively in the playroom. Even though the students were provided an appropriate person, setting, and opportunity to play with toys that allowed the expression of anger and other feelings, there was an absence of aggressive play, which was atypical of deaf and hard of hearing children (Leigh, Robbins, Welkowitz, & Bond, 1989; Watt & Davis, 1991).

Possibly because of the intense emotional isolation and yearning to be known and understood that also typically characterizes deaf children (Allen, 1986; Elliott, Glass, & Evans, 1987; Bebko, 1998; Cates 1991; DeSelle, 1994), the students in this study may have derived so much pleasure and affirmation during their play sessions that they had not yet reached the point in the therapeutic process of expressing unresolved aggression. The videotaped sessions, presented during weekly filial therapy training sessions, depicted student after student who seemed to radiate an innocent joy as he or she played in the presence of his or her attentive teacher. It appeared that the more the teachers communicated understanding and acceptance through gesture, facial expression, the spoken word, and sign language, the more the students seemed to bask in the warmth of a newly-found closeness and sense of being understood by their teachers. It is the researcher's opinion that the unexpected lack of aggressive play, in a population known to carry high levels of frustration and aggression, was superseded by the depth of bonding that was occurring through the intimate student-teacher play times.

Students in the filial therapy experimental group did not demonstrate a significant increase ( $p > .05$ ) in Sociable/Communicative Behaviors as measured by the Meadow-Kendall Social-Emotional Assessment Inventory for Deaf and Hearing Impaired Students in comparison to the non-treatment comparison group at the time of posttesting. Also, the effect size for the treatment effects was negligible (.007). This suggests that students whose teachers participated in filial therapy were not perceived by their teachers as exhibiting markedly increased sociability and communication with their teachers in the student-teacher play sessions, in the classroom, or on the playground. Although deaf children have been shown to exhibit more withdrawn and internalized behaviors and less social contact than their hearing peers (Hindley, 1997; Kalivoda, Higbee, & Brenner, 1997), the absence of a significant increase in Sociable/Communicative



Behaviors is initially puzzling in light of the significant decrease in Total Behavior Problems and Internalizing Behaviors as well as the positive trend toward a decrease in Externalizing behaviors on the CBC/C-T. Also, this finding is contrary to research in filial therapy in which children have shown significant increases in their ability to relate positively with others, including less emotional and social withdrawn behaviors, and a reduction of aggressive, delinquent behaviors, (Smith, 2001, Landreth & Lobaugh, 1998; Kale, 1997; Bratton & Landreth, 1994). Further, there were no significant decreases in Impulsive/Dominating Behaviors or Anxious/Compulsive Behaviors in the experimental group students, when compared with the non-treatment comparison group students. Additionally, the overall lack of significance shown in these behaviors is puzzling because of the significant reduction shown on similar behaviors on the CBC/C-T.

In an effort to understand these results, a more thorough test was run on the assumption of homogeneity of regression between the dependent variables (posttest scores) and covariates (pretest scores) on the Sociable/Communicative Behaviors, Impulsive/Dominating Behaviors, and Anxious/Compulsive Behaviors subscales, within each of the two groups. While there were no significant interactions shown between the covariates and treatment effects on the Dominating/Impulsive Behaviors scale and the Anxious/Compulsive Behaviors subscale, the results indicated that there were notable, though not statistically significant, unexplained interactions between the covariate and the treatment effects on the Impulsive/Dominating Behaviors subscale. Further, a review and comparison of the individual scores, gain scores for both groups, and t-tests for independent samples revealed no significant differences between groups on the subscales examined. Also, no meaningful patterns or trends were discerned in reviewing and further analyzing the scores of the experimental and control groups.

The lack of a significant increase in Sociable/Communicative Behaviors runs counter to the anecdotal accounts of a number of experimental group teachers. For example, one teacher's ratings on the SEAI indicated a notable decrease of sociable behaviors and attempts to communicate by her student of focus, a three-year old deaf child who prior to the filial therapy training, communicated and socialized very little with other children and teachers. In spite of her responses on the SEAI the teacher related: "At first in the playroom Cecilia would never say anything. She would occasionally look over at me. Towards the end of the play therapy experiment she began to play with more and different toys in the playroom. I also noticed that in the classroom she began to make friends and play with the other children, instead of playing alone. Everyday she is participating more and talking more. I believe the play therapy was a large part of this change in Cecilia. I believe that several other children in my class could also benefit from play therapy." The researcher is at a loss to explain this teacher's report of the change in the student's behavior, as observed in the playroom and classroom, while her posttest scores on this subscale of the SEAI do not indicate such changes. Perhaps the changes were not remarkable enough to be regarded as significant by the teacher or the instrument is not sensitive to such changes. But this example appears typical of the teachers' judgment regarding the students' lack of significant increase in Sociable/Communicative Behaviors, as measured by the SEAI, and their anecdotal accounts of the students' overall increased attempts to communicate and socialize with teachers and peers.

The students in the filial therapy group did not demonstrate a significant decrease ( $p > .05$ ) on the Impulsive/Dominating Behaviors subscale of the SEAI in comparison to the non-treatment comparison group. The effect size realized by the treatment effects was small (.043). This means that the students who participated in filial therapy did not decrease behavior

associated with dominating others physically or emotionally. Because dominating, aggressive behaviors are well-documented among deaf and hard of hearing children (Alpin, 1987; Elliott, Glass, & Evans, 1987; Schirmer, 2000), as are impulsive, externalizing behaviors (Luterman, 1999; Mantaninin-Manfredi, 1993, Vernon & Andrews, 1990), and filial therapy has been shown to significantly decrease such behaviors in children (Smith, 2000; Landeth and Lobaugh, 1998; Tyndall-Lind, 1999; Kot, 1995), similar results were expected on the SEAI. Further, since significant reductions in Externalizing Behaviors were indicated on the CBC/C-T, similar results were expected on the SEAI. As mentioned, a review of the pretests of the children in the experimental and non-treatment comparison groups indicated no discernible pattern or trend in the scores. A t-test for independent samples on the scores for Impulsive/Dominating Behaviors did approach significance ( $p = .059$ ), indicating an interaction between the covariate and treatment effects, thus making the results of the ANCOVA less than trustworthy. Still, the lack of significant reduction in Impulsive/Dominating Behaviors on the SEAI is puzzling.

The lack of significant results is also puzzling because it differs from the teachers' reported improvements in these behaviors in their students, as well as their absence on the teachers' videotapes of sessions with students. In the filial therapy training sessions, the impulsive, dominating, aggressive behaviors of the students on the playground and in the classroom were noted and discussed. However, as mentioned earlier, none of these behaviors were observed with individual students and teachers during their videotaped play sessions. In this regard, one teacher chose as her child of focus a 4 year-old student who was very impulsive and sometimes aggressive, but not to the point of undue concern. In reacting to their play sessions, and subsequent relationship, this teacher reported: "Sean had very limited sign language vocabulary. During our play times, I noticed that he had started to open up and was

becoming more interested in sign language, and in communicating with others. I do feel that because of the one-on-one time we have spent in the playroom, a trust has developed between the two of us that did not exist before. Prior to play therapy, Sean would rarely seek me out to assist him in some manner. Now, and even as early as after three sessions, I noticed that he would ‘look’ for me whenever he had a problem. He makes a real attempt to communicate to me whatever his concerns are. Also, the lack of ‘No’s’ in the playroom seems to have helped to boost his confidence in knowing that he is playing in appropriate and acceptable ways with the toys of his choosing.” It is possible that the teacher’s caring, empathic responses initiated a much-needed and wanted new kind of emotional bond between student and teacher. The establishment of this bond may help account for the teacher’s report of the reduction in impulsive, aggressive kinds of behaviors in Sean. Still, his anecdotal report contradicts the item scores of Sean’s Impulsive/Dominating Behaviors on the SEAI that reveal a substantial increase in these types of behaviors.

The students in the filial therapy group did not demonstrate a significant decrease ( $p > .05$ ) on the Anxious/Compulsive Behavior subscale of the SEAI in comparison to the non-treatment comparison group. Also, the effect size realized by the treatment effects was negligible (.0003). This suggests that the children who participated in filial therapy were not perceived by their teachers as showing notably decreased behaviors associated with symptoms of anxiety and compulsion: heightened fear and hypervigilance; feelings of worry and apprehension for no discernible reason; unexplained physical symptoms such as heart palpitations or head and stomach aches; phobic symptoms; or compulsive, ritualistic behaviors.

As noted earlier, deaf and hard of hearing students are known to manifest behavioral symptoms of anxiety, even to the point of compulsive behaviors (Watt & Davis, 1991). In

addition, since significant decreases were noted on the Internalizing and Withdrawn subscales of the CBC/C-T, and positive trends toward the reductions of Anxious/Depressed Behaviors were also seen on the CBC/C-T, similar reductions were expected on the Anxious/Compulsive subscale of the SEAI. Further, as it has also been well-documented that children whose parents have participated in filial therapy training have shown significantly fewer anxious behaviors in their parents' evaluation at posttesting (Smith, 2001; Bratton & Landreth 1995; Bavin-Hoffman, 1994), similar results were expected on this scale of the SEAI.

An examination of the teachers' individual item and larger grouping scores did not reveal noteworthy trends or an explanation for the wide range of scores evinced between pre and posttest in both the experimental and non-treatment comparison group. The possibility exists that the SEAI may not have been useful in measuring changes in this group of teachers and students.

The SEAI was chosen by the researcher as an evaluative instrument for this study for three reasons: 1) there is a notable scarcity of available instruments that are normed specifically for deaf and hard of hearing children; 2) the SEAI is normed for deaf and hard of hearing children; 3) along with other instruments, the SEAI has occasionally been used diagnostically by the Callier Center with its deaf and hard of hearing students. Despite its being normed for deaf and hard of hearing students, the SEAI generally did not meet the researcher's expectations with this group of students and teachers. There were no significant reductions in any of the behaviors measured by the SEAI. After the filial therapy training was finished, the Director and Associate Director of Education of the Callier Preschool expressed concern for the practical use of the SEAI based on their prior experience with it, despite the notable contributions to research in the field by its author. Because of their questions as to its practical use with their student population, they decided to use it sparingly. In a similar manner, it is possible that for reasons unknown to

the researcher, the SEAI did not appear workable with this group of teachers and students in this study.

Two other possible explanations come to mind. It is also possible that the SEAI was worded or constructed in such a way that the teachers were unable to grasp the intent of the questions. It is further possible that the students, in the judgment of their teachers, did not display enough increase in Sociable/Communicative Behaviors, or reduction of Impulsive/Dominating or Anxious/Compulsive behaviors to warrant significance. If this is so, however, the lack of notable reduction in Anxious/Compulsive Behaviors does not fit with several of the teachers' anecdotal comments regarding their playroom experience with the students.

One teacher, for example, in commenting on her five year-old hard of hearing child's experience said: "As we had more sessions, Kayla started to venture out playing with more of the toys, illuminating the room with her big smile or a giggle and exhibiting the freedom to be a child instead of a little caretaker, which she has to be for younger siblings at home. There were times when she was not at school and we had to miss our play sessions (later made up) and it showed in Kayla's behavior in the playroom and the classroom. Gradually, Kayla began to sign, vocalize more, and gesture to me in her attempt to relay a message about her play... Kayla has benefited tremendously from our play therapy sessions. Her personality has emerged, she is making more independent choices, and most importantly, her self-esteem is blossoming.

I want to note that on some occasions, Kayla came to school looking worried and sad. She would lie around and refuse to participate in group. Kayla was worried about her mother's health (her mother had been in and out of the hospital several times during the period of the research project, researcher's note). However, as we entered the play room together, and she

settled into her familiar routines of play and I began to respond to her play, I could see her concerns subside.”

It is possible that for this child, burdened as she was with concern for her mother’s health, trying to function as a viable caretaker to her brothers and sisters, while at the same time struggling with her own hard of hearing challenges, the playroom and the unique relationship afforded by the filial therapy training, provided enough of whatever she needed to begin to unburden herself and move toward a new level of healthy functioning in a relatively brief period of time.

### Implications for Future Research and Recommendations

Filial therapy has already been shown by other researchers to be a viable means of enabling both the child and parent to make positive changes in themselves, as well as within the parent-child relationship and the entire family constellation (Hoffman et al., 1991; Lebowitz, 1982; Lahti, 1993). Also, Guerney (1970) and others have suggested the efficacy of training teachers as therapeutic agents with their students, while White, Draper, Flynt, Jones and O’Shaughnessy (1997; 1998; 1999; 2001) have demonstrated the case for the use of Adlerian play therapy with teachers and students in a school setting. However, this study focused on the viability of teaching preschool teachers of deaf and hard of hearing children the primary filial therapy skills, child-centered play therapy skills. Teaching this group of teachers child-centered play therapy skills appeared to be more appropriate for these teachers and students because of the students’ already limited ability to acquire and use language. While the teaching and learning of Adlerian play therapy skills may be appropriate for teacher use with students in some school settings, the added emphasis on helping the child to understand or frame the play therapy experience in terms of the principles of Adlerian psychology appear out of place here.

Allowing deaf and hard of hearing students to move forward in the playroom, under their own guidance, at their own pace, with no requirement that they “speak” or communicate about their experience, at all, or within a prescribed frame, and all with the teacher’s focused attention, appeared more workable with these teachers and students. Hence, it is possible that this training program could be further refined and developed to assist the teachers in becoming even more adept at functioning as therapeutic agents with their students. As mentioned earlier, all of the teachers in the experimental group (and a number of teachers from the control group) expressed a genuine interest in establishing this program (or a future derivative of it) as a permanent part of the program that the Callier Preschool offers to all teachers and students. Having the training program for teachers and play sessions for students available to all of the deaf and hard of hearing students at Callier could add a significant component to their already outstanding educational plan and mission for their present and future students.

In this regard, it may be appropriate to offer a few recommendations for the future. A list of recommendations follows:

- 1) Incorporate filial therapy training as a part of the required training program for all teachers in schools for the deaf and hard of hearing.
- 2) Provide filial therapy training to all Preschool Directors of Education and key administrative staff in schools for the deaf and hard of hearing.
- 3) Extend future filial therapy training programs from 10 to 20 weeks, or from one to two semesters to allow time for more changes in behavior for students and teachers.
- 4) Require filial therapy training for the parents of all deaf and hard of hearing children who enter preschool.



- 5) Provide filial therapy training as part of the university undergraduate curriculum for those seeking to become certified deaf educators so that they will begin the training earlier in their teaching careers.
- 6) Conduct a follow-up study of the results of this study, incorporating planned follow-up evaluations at six months, a year, and two years to examine whether changes notes at the conclusion of the study maintain over time.
- 7) Build and equip a larger, more fully-furnished, permanent playroom at the Callier Preschool facility so that teachers will have more ready access to the playroom for the benefit of their students.
- 8) Create and implement a task group or work group to more carefully translate into American Sign Language the usual filial therapy responses to children's play behaviors and feelings.

### Concluding Remarks

Deaf and hard of hearing preschool children struggle to overcome their lessened ability to learn to communicate, to use language meaningfully. Since the ability to acquire and use language to communicate is a necessary component in the universal need of humans to relate socially in meaningful ways with others, any treatment regimen that can further the efforts of teachers of deaf and hard of hearing children, appears worth consideration. This research study has demonstrated that preschool teachers of deaf and hard of hearing children may become even more effective in assisting their students by learning and applying the basic skills of filial therapy training in one-to-one, special play sessions with their students. The study suggests that by learning the filial therapy skills and applying them in regular play sessions with a student of focus, both the teacher and student develop a different, more helpful quality of emotional

relationship. This developing relationship has been shown to positively impact the students' troublesome behaviors both in the playroom, classroom, and on the playground. The study has also suggested that classroom teachers of deaf and hard of hearing children are capable of learning and applying filial therapy skills in a helpful manner and integrating them into their broader regimen of "helping skills" that are used by all teachers of deaf and hard of hearing children. Finally, the study suggests that play may well be the universal "language" of children, even for children whose primary difficulty in life is acquiring and learning to communicate and master a language they cannot hear, without the use of play.

## APPENDIX A

### DESCRIPTION OF THE RESEARCH PROJECT FOR PARENTS AND TEACHERS

## ***PLAY THERAPY TRAINING FOR TEACHERS:***

### **TEACHERS HELP THEIR STUDENTS THROUGH *FILIAL THERAPY***

Research Information for Teachers

*“Toys are the words and play is the language of children.”*

Virginia Axline (1947)

As a preschool teacher of deaf and hard of hearing children, this letter gives information on a proposed research study to determine the effectiveness of play therapy training for teachers (clinically termed filial therapy) with deaf and hard of hearing children. **This study has been approved by the UNT Committee for the Protection of Human Subjects. Participation in this study is voluntary. You will in no way be coerced to participate. If you decide not to participate, there will be no consequences to you in terms of your teacher evaluation, your students’ evaluations, your job, or your relation to the researcher.**

**If you decide to participate, you will be assigned to either an experimental or control group. You will then be asked to select one of your students, between the ages of 3 and 5 years, to be your *student of focus* with whom you will do pre-and posttesting only (if you are in the control group), or, in addition to the pre-and posttesting sessions, you will receive filial therapy training and have weekly teacher-student play times (if you are in the experimental group). Both experimental and control group participants will be asked to complete two questionnaires on your *student of focus* and to have one 20 minute playtime as part of the pre-and posttesting sessions.** Experimental group members will receive filial therapy training and do weekly special play times with their student of focus throughout the fall semester.

**Precursor to Filial Therapy Training with Teachers: Filial Therapy Training with Parents:** Empirical research that supports *Play Therapy Training for Parents* as a preventive and clinical intervention for increasing the self-esteem and reducing problem behaviors in the children of parent participants. Filial Therapy training is a unique training program that utilizes the already existing bond between parent and child, thus the clinical term *filial therapy*. Adults are taught the core concepts and skills of play therapy in order to become a therapeutic agent of change in children’s lives. The initial filial therapy training model focused on strengthening the parent-child relationship as opposed to the counselor-child or teacher-child relationship. Rather than focusing on the child’s problems, the training focuses on the whole person of the child and helps adults to understand and respond effectively to children’s emotional needs, to increase the child’s self-esteem and to set limits so as to foster self-discipline within the child.

**Despite empirical evidence supporting the use of parents as therapeutic agents of change with their children, THERE IS ALMOST NO OBJECTIVE EVIDENCE**

## **SUPPORTING THE USE OF TEACHERS AS THERAPEUTIC AGENTS OF CHANGE WITH THEIR STUDENTS.**

The proposed research project will investigate the efficacy of training preschool teachers in filial therapy for use with their students. It is widely accepted that deaf and hard of hearing children experience greater emotional and behavioral difficulties because of their delay in the acquisition and use of language and other communication skills. Filial therapy training will offer the opportunity for you to function not only as a teacher, but also as a therapeutic agent of change with your students.

Play therapy skills learned as part of your filial therapy training may generalize to your entire class of students.

**Teacher Training and Teacher-Student Play Times:** Experimental group members will attend training opportunities with one of several small groups of other teachers participating in the research project. As much as possible, these training opportunities will be tailored to your individual schedules at school. Training will take place at the Callier Center. Ten hours of training will be offered during the teachers' time at school. Ten additional training hours will be offered after school in blocks that meet teachers' schedules in either five two-hour, four two and a half hour, or three three and a half hour sessions. Make-up sessions will be made available when necessary.

To help you learn to use the new skills and simultaneously help your student of focus, you will conduct weekly private teacher-child play times, 30 minutes in length, with your student for a total of 7 to 9 play sessions during the fall semester. You will conduct play sessions using a furnished set of toys and play materials at a designated play area within the school. Three of your sessions will be videotaped and you will receive feedback and instruction from the researcher (and/or his research assistant) upon reviewing your videotape .

**Benefits:** Filial therapy training can benefit your student by: 1) improving your student's self-concept, 2) reducing his/her behavioral problems, and 3) improving your student's problem-solving skills. Furthermore, you and your student may enhance the quality of your emotional relationship, which can lead to more positive growth for the student. During the *Special Play Times*, your student may communicate symbolically through play, thoughts, feelings, experiences, and difficulties never before expressed to you or even to him/herself.

The aim of filial therapy training is **not** to train you to be a therapist with your students.

The aim of filial therapy training is to enhance your skills as a teacher of deaf and hard of hearing students. In this regard, filial therapy training can benefit you, the teacher, by: 1) increasing your ability to respond to students' emotional needs; 2) increasing your ability to nurture your students in times of crisis; 3) developing a new way of setting limits that fosters self-discipline rather than external control or punishment; 4) reducing your stress as a teacher; and 5) further enhancing confidence in your effectiveness as a teacher with special needs children.

**Confidentiality:** The information you provide on the questionnaires will be kept confidential. Your name and your student's name will not be disclosed in any publication or discussion of the material. Information from the questionnaires will be coded with only the researcher, D. Michael Smith, having a list of the participants' names. At the end of this study,

the list of participants' names and the videotapes will be destroyed.

Please give serious consideration to participating in this research project. The results of the research could make a significant difference in the educational planning and provision of services to future deaf and hard of hearing students, as well as your own.

If you agree to participate, please fill out and sign the consent form attached to this page. For further information, please contact Michael Smith, 214-750-1086 (work) or 214-369-7670 (Home). Thank you very much for your time, cooperation, and participation.

APPENDIX B

INFORMED TEACHER CONSENT FORMS

PLAY THERAPY TRAINING FOR TEACHERS:  
(FILIAL THERAPY TRAINING)

You are making a decision whether or not to participate in this research study. You should not sign until you understand all of the information presented to you concerning this research project and until all of your questions about the project have been answered to your satisfaction. You understand that participation is voluntary and you and/or your student/child of focus may choose to withdraw at any time during the study. Your signature indicates that you meet all of the requirements for participation as explained by Michael Smith and have decided to participate, having read the information furnished about this research study.

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Signature of Teacher	Date
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Name of Child/Student of Focus (When selected)	Date
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Signature of Witness	Date
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Researcher/Instructor:  
D. Michael Smith, M.Div., LMFT, RPT-S  
Center for Family Care  
8330 Meadow Rd., Suite 114  
Dallas, Texas 75231  
214-750-1086

Major Professor:  
Garry Landreth, Ph.D.  
Counseling and Higher Ed.  
University of North Texas  
Stovall Hall, 155  
Denton, TX  
IRB PHONE: 940-565-3940



APPENDIX C

INFORMED PARENTAL CONSENT FORMS

PLAY THERAPY TRAINING FOR TEACHERS  
FILIAL THERAPY

Informed Consent for Students' Parents

UNT IRB PHONE NUMBER: 940-565-3940

Dear Parent(s):

Your child has been selected by his/her teacher at the Callier Preschool for possible volunteer participation in a research study at the preschool. The research project will be conducted with the approval of Ms. Karen Clark, Director of Education and Ms. Gail Wilson, Assistant Director of Education, at the preschool and the approval of the Dallas Independent School District. The study will be conducted by D. Michael Smith, doctoral student at the University of North Texas in Denton.

**This study has been approved by the UNT Committee for the Protection of Human Subjects. Participation in the study is entirely voluntary.** This study is designed to determine the effectiveness of training teachers at the Callier preschool to use the basic skills of play therapy (filial therapy) with their students at the school.

The researcher anticipates that training the teachers in the use of play therapy skills with their students will make it possible for them to do an even more effective job of teaching and enabling your deaf or hard of hearing child to overcome the challenges that lie before him or her. The training could significantly assist the teachers as they equip your child to take a meaningful place among the solid citizens and leaders of tomorrow.

**Should you decide for your child to be a volunteer participant, your child's participation will be strictly confidential.** If your child's teacher agrees to participate, and if you decide for your child to participate, your child's teacher will be assigned to one of two different groups. Your child's teacher will be assigned to one of two different groups. Both groups will be evaluated before and after the teacher training process. But only one group will receive the special teacher training. During the fall semester (September through December), only one group of teachers will receive training in the use of play therapy skills with their students. The other group will not receive the training at this time.

**If you agree for your child to participate, you are agreeing for your child's teacher to administer two evaluative instruments for pretesting purposes and to be videotaped for 20 minutes with his/her teacher in a play session with toys provided by the researcher. Teachers and students in both groups will take part in this portion of the project. At the end of the fall semester, the teacher will readminister the same two instruments and the teacher and student will once more be videotaped in 20 minute play session with the same toys.**

**Measuring the difference between your child's scores on the tests before and after one group of teachers has been given the special training will tell how much the testing has been helpful to your child and your child's teacher. All evaluations will take place during school time.**

In addition to the two evaluative instruments administered by the teacher before and after training, if you agree for your child to participate in the study, you will be giving permission for your child to take part in the pre-and posttesting sessions, including the 20 minute videotaped session. Students whose teachers receive the special training will then also spend 30 minutes each week with their teacher in a special playtime at the school. During this time, your child's teacher will practice the play therapy skills he/she has been learning during the teacher training. All your child will be asked to do is to play with the toys available in most of the ways your child decides. The teacher will be with your child the whole time, then they will go back to their regular schedule for the day.

Approximately three times during the fall, your child's teacher and your child will be videotaped together as they participate in their special playtime. These videotapes will be strictly confidential and will be used for informational purposes only as part of the research project. They will be destroyed at the end of the project, as will your child's test records, and any information involving your child's participation in the research project.

Please seriously consider giving permission for your child to be a volunteer participant in this research study. Not only your child, but many other deaf and hard of hearing children could benefit in the future as a result of this study.

I welcome any questions you may have about the study or your child's participation in the study. Or you may consult Karen Clark, Gail Wilson, or your child's teacher if you have questions. You may also call me and I will call you back as soon as I am able.

Thank you so much for your consideration.

Very truly yours,

D. Michael Smith, M.Div., LMFT, RPT-S  
Researcher and Instructor for the Research Project  
8330 Meadow Rd., Suite 114  
Dallas, Texas, 75231  
214-750-1086(w) 214-369-7670(h)

## AGREEMENT TO PARTICIPATE

I (put your name here)\_\_\_\_\_ am  
the parent/legal guardian of (put your child's name on the line below)  
\_\_\_\_\_.

I hereby give permission for my child \_\_\_\_\_  
to participate as a volunteer student in the research study described above. I  
understand that my child will be the student of focus for his/her teacher  
(put your child's teacher's name here) \_\_\_\_\_  
and that my child's teacher and my child will be assigned to one of two groups.  
Students and teachers of both groups will participate in the pre-and posttesting  
portion of the study. Students and teachers of only one group (the experimental group)  
will receive filial therapy training at this time. Students and teachers in this group will  
have weekly play sessions that will be videotaped for research purposes only.

I understand that my child's participation in this study is confidential. I also  
understand that my child's participation is voluntary and that I may withdraw my  
permission to participate at any time.

Signed, \_\_\_\_\_

Date \_\_\_\_\_

Teacher's Signature and Date \_\_\_\_\_

Witness \_\_\_\_\_

Principal Researcher's

Signature \_\_\_\_\_

**Major Professor:**

**Dr. Garry Landreth, Ph.D.**

**Regents Professor**

**Department of Counseling, Development, and Higher Education**

**University of North Texas**

**Stovall Hall 155**

**Denton, Texas**

**940-565-2916**

**Human Subjects Review Board**

**940-565-3940**

APPENDIX D

STUDENT'S AGREEMENT TO PARTICIPATE

**STUDENT'S AGREEMENT TO PARTICIPATE  
(STUDENT CONSENT FORM)**

I understand that my teacher is learning play therapy with Michael Smith and that he or she will have “special playtimes” with me as part of her homework. I understand that I am a volunteer and that I can choose to stop participating by telling my parents, my teacher, and Michael Smith

**MY NAME IS** \_\_\_\_\_.

**MY AGE IS** \_\_\_\_\_.

**THE NAME OF MY TEACHER IS**

\_\_\_\_\_.

**I AGREE TO PARTICIPATE IN THE STUDY WITH MY TEACHER.**

**SIGNED** \_\_\_\_\_.

D. Michael Smith, LMFT, RPT-S  
214-750-1086

Garry Landreth Ph.D.  
940-565-2916

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